

Consumers as Providers of Mental Health Services

A Literature Review & Summary of Strategies to Address Barriers

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Introduction

Nationally, consumers working as providers in mental health have become increasingly recognized as positively enhancing the provider system. Consumer-providers have many attributes that positively effect the work such as their experience and direct knowledge of mental illness, their unique perspective from being in the system, and providing positive role models for other consumers.

In the spring of 1997, the University of Kansas, School of Social Welfare (KUSSW) held a Supervisor's Symposium entitled "Maximizing Consumer Choice, Opportunity and Participation in Mental Health Services. At the symposium, an esteemed consumer advocate, psychiatrist, and consumer, Dan Fisher, gave a keynote address. Dr. Fisher talked about the power and importance of consumers working within the mental health system. This keynote address was the impetus of the Consumer-Provider Project initiated by the University of Kansas, School of Social Welfare and supported by the Kansas Department of Mental Health and Developmental Disabilities.

In Kansas, some mental health centers have been hiring consumers as providers. However, in a survey conducted of the CSS Directors in Kansas, hiring of consumers is sparse, and there are many barriers identified in doing so.

In the summer of 1998, KUSSW conducted a review of the literature identifying the benefits, barriers, and strategies for overcoming the barriers to hiring consumers as providers. This review of the literature is contained in this manuscript (Chapter 1). The literature revealed many benefits as well as a

multitude of barriers. Strategies identified for overcoming the barriers, however, were minimal at best.

The University of Kansas School of Social Welfare sponsored two forums on consumers as providers - one held in August of 1998 and another in December of 1998. The purpose of these forums was to identify the barriers and brainstorm solutions or strategies to overcome the barriers identified.

Participants invited to the forums consisted of both consumers working as providers in the mental health system, professionals who have hired and/or supervised consumers, and mental health administrators wanting to hire consumers as providers, but have not done so due to the barriers encountered.

The group consisted of approximately half consumer-providers and half non-consumer providers. Chapter 3 of this manuscript contains the strategies that were produced during the forums in combination with the strategies identified in the literature.

Throughout the process of reviewing the literature, talking with administrators, supervisors, and consumer-providers, and conducting the forums, four main themes emerge:

1. **There are definitely strategies available to overcome the barriers presented to professionals and consumer-providers.** The Consumer-Provider Forum was particularly helpful in identifying, even for the most overwhelming obstacles, strategies that could work. Three of the most powerful barriers included dual-relationships, confidentiality, and stigma. Chapter 3 outlines all of the strategies for each of the barriers identified.
2. **Other fields such as addictions and welfare have used consumers as providers.** In fact, many mental health centers in Kansas that have alcohol and drug treatment programs have hired “recovering” persons who are or have been involved in services in the programs in which

they work. However, in mental health – particularly when thinking about people with major psychiatric disabilities, it appears that the barriers and fears around dual relationships and confidentiality are rooted in the long history of services provided under the medical model. If other provider fields in social services have been able to effectively use consumers as providers, the mental health field can certainly do so.

3. **If there are to be significant increases in the Kansas State mental health system with the hiring of consumers as providers, state policy must initiate this change.** The State Department of Mental Health and Developmental Disabilities, the State Association for Community Mental Health Centers, and the Consortium needs to provide a policy statement that supports consumer as providers in Community Mental Health Centers. These entities also need to develop a statewide policy on consumer-providers in mental health, including consensus on how to handle dual relationships and role conflicts for consumer-providers. There needs to be sanctioning from SRS and the Behavioral Sciences Regulatory Board (BSRB) of hiring consumer-providers, even if they have received services at that center.
4. **The organizational culture of the mental health center is key to the success of consumers working as providers within the mental health system.** In order for the successful integration of consumers into the provider system to occur, mental health agencies must adapt their organization to support this initiative. The nature of the organizational environment, both in the literature and the forums, was identified as critical to success. An agency that is open, flexible, values diversity, views clients as competent and significant contributors, and includes consumers in decision making are just a few of the attributes that lead to an organizational culture that supports consumers as providers. See chapter 1 (Review of the Literature) and chapter 3 (Challenges and Strategies) for more details.

Chapter 1

A Review of the Literature

I. Introduction

The practice of hiring consumers as providers of mental health services is relatively recent but ever increasing in the mental health field. However, in many other fields such as substance abuse, deaf/hearing impaired, HIV disease, and spinal cord injuries, employing consumers as part of the treatment team has been common practice (Fox & Hilton, 1994; Zipple, Drouin, Armstrong, Brooks, Flynn, & Buckley, 1997).

There has been significant progress in the recognition of the benefit of hiring consumers as service providers. In 1989, the National Association of State Mental Health Program Directors took the position that consumers "...have a unique contribution to make to the improvement of quality mental health services..." and "...their contribution should be valued and sought...in provision of direct services". In a national survey of mental health agency administrators conducted by the International Association of Psychosocial Rehabilitation Services (IAPSRS, n.d.), 63% of respondents either "strongly encouraged" or "encouraged" the hiring of consumers in their agency. Furthermore, 50% of respondents indicated that they hire consumers who currently receive services in their respective agency.

A survey of Community Support Service (CSS) Directors on hiring consumer-providers in Kansas, revealed 53% of the total respondents (ten out of

nineteen) currently employ consumers in their program (although it should be noted that some of these programs were referring to hiring as non-professional staff, e.g., clerical, custodial, drivers, etc.). Additionally, 84% of the centers reported that in the past they have hired consumers to work in their program.

There exists an invaluable opportunity for professionals to learn from consumers by working with them as colleagues in the provision of services. “Consumers do bring something distinctive to service encounters” (Moxley & Mowbray, 1997, p.3). Consumer providers can greatly enrich the organizational culture, leading to greater understanding and awareness of coping and recovering from psychiatric disabilities.

As with any new opportunity in service delivery, numerous dilemmas tend to arise. This literature review is intended to synthesize empirical findings; identify common elements of consumer provision of mental health services; and to find solutions to key questions posed by Community Support professionals, consumers and policy planners.

II. Benefits of Hiring Consumers

Consumers who work as service providers are viewed as a positive development and are receiving increasing attention from clinicians and researchers in the field (Miya, Wilbur, Crocker & Compton, 1997; Dixon, Krauss, & Lehman, 1994; Gallagher, 1997; Griffin-Francell, 1997). The benefits of hiring consumers as providers in mental health exist on multiple levels. As we might assume, there are benefits to the recipients of services from consumer-providers,

benefits to the consumer-providers themselves, as well as benefits to the system as a whole.

Benefits to the Consumers Receiving Services

In programs which hire consumers, numerous desirable attributes and abilities of consumer employees have been noted including: systems knowledge, “street smarts”, responsiveness, coping strategies, patience & flexibility, relational emphasis, issue identification, engagement abilities, role modeling, advocacy against stigmatization, and educational activity with co-workers (Van Tosh, 1993; Dixon, et al., 1994). Consumer-providers, by virtue of the position they have reached, instill hope. Hope, not only to the consumer-provider, but also to the consumers who receive services (Moxley & Mowbray, 1997; Brown, 1997).

In one year and two year follow-up studies of the effectiveness of consumers as providers, there was no statistical difference in the outcomes of clients served by consumer-providers and non-consumer providers (Solomon & Draine, 1995a; Solomon & Draine, 1995b). Outcomes reviewed in these studies include symptomatology, psychiatric hospitalization, subjective quality of life, social functioning, living situation, and satisfaction with mental health treatment. Studies also showed consumer-providers as having more interpersonal contact with clients than non-consumer providers (Solomon & Draine, 1996a) and more likely to provide face-to-face service contact with clients than non-consumer providers (Solomon & Draine, 1996b). In addition, Lyons, Cook, Ruth, Karver & Slagg (1996) found that consumer staff engaged in more street outreach.

Personal Experience. Consumer-providers bring their unique perspective to service delivery from someone who has likely had similar experiences. The service providers, therefore, make the service experience more normative, and relevant as they provide empathy based on their own knowledge of the illness (Moxley & Mowbray, 1997). Consumers as service providers have special knowledge and skills as a result of their personal experience of the illness and the mental health system (Miya et al., 1997). They have knowledge of navigating the mental health system and the ability to share and reflect on personal experiences (i.e., experiences with medications, sharing strategies for coping, etc.) toward achieving personal recovery which can be an important tool in the treatment approach to help others (Fox & Hilton, 1994). Experiences gained and lessons learned in recovery by the consumer-provider service as excellent resources for clients (Fisher, 1994). A consumer sharing her perspective on her role as a consumer-provider talks about the benefit of having a personal knowledge of the illness. "...I have been through their hell, they [consumers] know that I have a perspective on their work that non-consumer providers will never have" (Sweeney, 1997, p. 320). Another consumer-provider, employed as a psychiatrist, also shared, "...I like to believe that I have developed a healthy and professional balance in providing the best of psychiatric and professional care with the unique understanding that only someone who has been there can have" (North, 1997, p.300).

Serving as a Role Model. Hiring a person with a psychiatric disability can serve as a powerful role model for individuals served by their respective agency (Shepard, 1993; Boykin, 1997). Consumer-providers have experienced similar life course (hospitalization, loss, stigmatization) of the consumers who they serve. However, their success with employment, education and independent living is a powerful role model in the belief that recovery is a reality (Boykin, 1997).

Benefits to the Consumer Provider

Research has demonstrated the benefits for consumers working as providers in the mental health system. Working as a provider empowers consumers by increasing their sense of value and self worth as well as providing avenues for personal growth and development (Moxley & Mobray, 1997; Boykin, 1997). My illness “has become the motivation and catalyst for my desire to help others to understand themselves. I have found that by helping others, I help myself” (Gallagher, 1997, p. 312). Boykin (1997) describes her work as a consumer-provider as empowering, resulting in an increased sense of responsibility, and a feeling of contributing and living a more normal life.

Results of several studies suggest personal benefits to the consumer-provider. A project designed to train mental health consumers for employment as case management aids revealed that a significant number (15 out of 17) of those consumers retained employment at a two-year follow-up. The fifteen case management aids still employed after a two year period had only required a total of two bed-days of psychiatric hospitalization since the training ended (Sherman

& Porter, 1991). Another study of consumer case managers found that there were no greater signs of stress, decreased self-esteem or burnout among the consumer providers compared to the non-consumer providers (Solomon & Draine, 1996a). A study by Mobray, Moxley, Thrasher, Bybee, McCrohan, Harris & Clover (1996) reported personal growth, increased self-confidence, and developing specific skills for consumers assuming the role of provider.

Benefits to the System

Consumer-providers are an avenue for education of staff and administration. Their presence can heighten staffs' awareness and sensitivity to the struggles faced by consumers. They can provide insight and facilitate understanding which may help non-consumers face challenging situations with consumers (Francell, 1996). The consumer-provider can also help professional staff become aware of their own prejudices and ways they may stigmatize clients (Miya, et. al., 1997; Dixon, et. al., 1994). Consumer-providers can also help to shift professionals' negative attitudes about the poor prognosis of people with serious mental illness (Sherman & Porter, 1991). The hiring of consumers adds different perspectives, brings understanding and diversifies the work environment (Bichsel, 1997; Shepard, 1992) as well as enhance sensitivity towards the consumers the agency serves (Shepard, 1992).

The practice of hiring consumers attests to the values and philosophy of the mental health agency. It conveys to workers that consumers are important, they are capable as human beings, and bring valuable experience to the work (Mobray & Moxley, 1997). In addition, consumer-providers significantly impact

an agency by increasing the likelihood that the consumer voice is integrated in planning, evaluating and developing services (Bichsel, 1997). When consumers belong to an organization, they are frequently engaged in providing feedback through various mechanisms in the delivery and evaluation of services.

III. Challenges and Strategies

Dual Relationships

A primary barrier to hiring consumers as service providers in Kansas has been the concern over the existence of dual relationships. Professional associations have defined dual or multiple relationships as a situation in which a professional relates to a client in more than one relationship, i.e., professional, social, personal, business, or financial (NASW Code of Ethics; The Ethical Principles of Psychologist Code of Conduct). Dual relationships are of concern when a consumer is hired as a provider and is currently or has in the past been a client of the same agency.

Dual relationships have been considered unethical in human services because of the potential risk of harm or exploitation to the client. An example of the response by professional associations to dual relationships exists in the Social Workers Code of Ethics:

“Social workers should not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client...Dual or multiple relationships occur when social workers relate to clients in more than one relationship, whether professional, social, or business.”

Another example can be located in the Code of Conduct, Ethical Principles of Psychologists (1.17(a) Multiple Relationships):

“A Psychologist refrains from entering into or promising another personal, scientific, professional, financial, or other relationship with such persons (patients, clients, students) if it appears likely that such a relationship reasonably might impair the psychologist’s objectivity or otherwise interfere with the psychologist’s effectively performing his or her functions...or might harm or exploit the other party.”

The literature on dual relationships related to consumers as providers is relatively sparse. The problem is frequently identified, however, rarely are strategies and solutions provided. An ongoing debate is whether to hire consumers who are receiving services from their respective agencies due to the heightened ethical dilemmas surrounding dual relationships. Some professionals would assert that the mental health profession should refrain from hiring consumers served by the agency. Others in the mental health community might argue that “being a professional does not preclude seeking help within the same service system, but an employee may need to arrange supports to avoid conflict with professional responsibilities” (Fox & Hilton, 1994, p. 629).

Shepard (1992) discovered two generalizations about dual relationships: (1) staff members with disabilities were more clear than non-disabled staff about dual-roles and when each role applied; and (2) the non-disabled staff experienced more difficulty sorting out licensure issues as well as situations in which personal information was divulged with other workers who also received services from that agency.

Another ethical conflict surrounding dual relationships is concerned with the nature of consumer-provider’s relationship with other consumers. The importance of consumer-providers’ need to maintain ties with their friends is recognized as an invaluable source of continued support. Such support is

manifested through continuing relationships with the self-help movement and through peer support which helps to maintain their roots as users of the mental health system (Shepard, 1992). In contrast, many professionals in the field including consumer-providers have difficulty with the blurred boundaries that develop when a consumer-provider continues friendships with consumers within the same agency they are working.

In a study of consumer-providers belonging to an Assertive Community Treatment (ACT) Team, boundaries and relationship parameters between consumer-providers and the people they served were reported to be more unclear than those between non-consumer providers and their clients (Dixon et al., 1994). In addressing boundary issues for consumer-providers, Dixon set up several role expectations: (1) the consumer-provider was as accountable to the team as any other member; (2) the consumer-provider was expected to bring all relevant information to other team members; and (3) supervision was directed at assisting the consumer-provider in discerning what information to share with the rest of the team.

One solution to address the issues of dual relationships in larger metropolitan areas has been the adoption of policies that do not allow the consumer-provider to receive services by the agency in which they are working. Agencies in the metro areas either hire from outside of their agency or insist that the consumer-provider hired from within their agency transfer service to another agency. Such policies help to prevent the ethical dilemmas that occur with dual relationships, but they can also present other problems. Consumers may be

forced to disrupt services and relationships that have helped to enhance and maintain the progress they have made. Disruption of such services can lead to major setbacks in their recovery. Additionally, in smaller rural communities, consumers usually do not have alternative access for services in their area. Therefore, changing service providers becomes problematic due to the long distances between service provider agencies.

With regard to boundary issues, Mobray & Moxley (1997) suggests that agency staff are “no longer guided by arbitrary distancing and noninvolvement rules, but must make such determinations on an individual basis, using their own good judgment” (p. 522). A key strategy in addressing dual roles is to facilitate communication and dialogue about role confusion with all people involved (Shepard, 1992; Jonikas, Solomon & Cook, 1997). Agencies that embody a proactive stance by implementing supports for the consumer-provider and facilitating discussions concerning dual relationships within the work setting, promote understanding and acceptance of the consumer-provider role. To have administration and staff address factors such as stigmatization and power dynamics can help facilitate successful and satisfactory relationship development between non-consumer and consumer staff (Jonikas, et. al., 1997).

In addition to confronting dual relationships with open discussions, the literature suggests that agencies develop guidelines and policies addressing staff/client interactions (Jonikas, et al., 1997) as well as provide individual supports for consumer-providers such as job coaches, supervisors with more specialized training, support groups, etc. (Mowbray & Moxley, 1997).

Several specific policies have been noted in the literature. Harp (1991) writes that some agencies have adopted policies in which those relationships existing before a consumer became part of the staff team are allowed to continue, but that consumer-provider is not able to provide any services or be in any kind of supervisory position over the other person. Fox & Hilton (1994) recommend that the supervisor and consumer not have a past treatment relationship and should relate to the consumer only as an employee. Another common policy obligates consumer providers to limit or cease social relationships with consumer/clients currently receiving services (Jonikas et al., 1997). However, there are indications that this policy has promoted reluctance on behalf of the consumer-provider to take a staff position and, as noted earlier, presents a barrier for the consumer-provider to sustain natural supports from peers (Jonikas, et. al., 1997).

Zipple et al. (1997) suggests three strategies for addressing the attitudes and expectations of non-consumer staff toward their consumer colleagues. These strategies are designed to promote tolerance and appreciation for diversity in the workplace:

1. Acknowledge the conflict is possible, if not likely, and address it directly during orientation and training of new employees.
Employers should have clear expectations for employees' respect and acceptance for all individuals.

2. Create an environment where non-consumer staff feel comfortable discussing their discomfort and difficulties they may experience viewing consumer-providers as colleagues.
3. Work with consumer staff to develop an approach that educates and promotes acceptance without breaching their privacy.

It is also suggested that non-consumers receive training and support in their efforts towards the acceptance of consumer-providers as equals (Jonikas, et. al., 1997). Vinfen Corporation in Massachusetts provides services to a variety of special need groups and is committed to hiring individuals with psychiatric disabilities. This organization relates that "...ongoing training opportunities, has helped the organization to integrate and support employees with varied backgrounds and abilities" (Zipple et al., 1997, p. 408).

Role Conflict and Confusion

Related to the concern of dual relationships is the existence of role confusion or power struggles between consumer and non-consumer providers, and the impact of changing boundaries of these relationships (Jonikas, et al, 1997; Dixon, et al, 1994; Miya, et al., 1997). It has become evident that some amount of discomfort exists on the part of both the consumer-providers and non-consumer providers in developing working relationships as equals.

Discomfort for Non-consumer Providers

The discomfort on behalf of non-consumer providers evolves from the difficulty in accepting consumer-providers as equals (Zipple, et al. 1997). There is a historical basis that can explain the discomfort non-consumers experience. It is

important to consider the traditional roots of treatment where there has been a clear delineation between the “sick” and the “well”. With the introduction of consumers working within the mental health system those lines separating the sick from the well become blurred (Miya, et al. 1997). Miya recommends creating an agency culture that combats stigmatization, bias and prejudice by recognizing such prejudices and biases, and addressing it by creating more flexibility in workers roles.

A study conducted by Solomon (1994) indicated that mental health staff has difficulty accepting consumer-providers as “full fledged” members of the case management team. In some agencies, traditional staff treated consumers providers as “junior staff” rather than equals (Levin, 1997). In a study of consumer advocates working within an ACT Team Dixon et al. (1994) discovered that staff members were tempted to assume the role of therapist with consumer providers.

Discomfort for Consumer Providers

Consumers who transition from the role of consumer to one of provider may experience difficulty (Miya, et al. 1997; Mobray & Moxley, 1997; North, 1997; Shepard, 1992; Zipple et al. 1997). Consumer-providers have the difficult task of balancing their consumer identity and their new professional identity. Peers of the consumer-provider often perceive them as staff and lose trust in them. Co-workers may still perceive them as clients and not as equal colleagues. Consumers move from the role of being critics of the mental health

system to being members of it (Zipple, et al. 1997). Consumer-providers may feel isolated as if they are in “no man’s land” (Shepard, 1992).

In a study of consumer-providers working in an ACT Team, several consumer-providers reported that they “never had a collegial relationship with a provider and were clearly uncomfortable in that role” (Dixon, et al. 1994, p. 625). The example provided of this issue was of several consumer-providers who continued to use the medical director’s formal title of “Dr” instead of using her first name as did non-consumer providers.

“Being a pioneer carries its own burdens” describes Griffin-Francell (1997, p. 475). Being the first consumer hired by a mental health agency is analogous to being the first person of color employed by a white company or the first female serving on a corporate board (Griffin-Francell, 1997). In first person accounts of consumers who have become mental health providers, the struggle becomes clear. The lack of experience with this new role for consumers, in addition to traditional biases and attitudes that reflect the sense that consumers are somehow “different”, make the role transition a challenge. “It’s been an uncharted road that I have traveled upon deciding to reveal the details of my personal psychiatric history for public consumption. There was no one to guide me, no mentor who had been there before” (North, 1997).

Still, while some consumers struggle, others have taken a different, more optimistic attitude. “I never felt any self-consciousness or feelings of inferiority when working with non-consumers...I guess I adopt the attitude... that being a recovering consumer is an advantage (Francell, 1996, p.30)

One solution to address the role confusion some experience is to have roles and responsibilities clarified (Solomon, 1994). Often times, the roles and responsibilities of consumer-providers in the workplace can be vague. In several programs that use consumer-providers, role expectations and job duties were unclear which lead to ambiguity in the work (Dixon, et al, 1994; Hildebrand, Jardine, McVay, O'Dell & Zurek, 1997). One avenue for delineating responsibilities is to utilize clear job descriptions (Hildebrand, et al. 1997).

Providers Maintaining Their Identity as Consumers and Risk of Co-optation

If one of the barriers of employing a consumer as a provider in mental health services is their ability to relate to the people being served, retaining a sense of their “consumerism” is critical. One danger consumer-providers face is the ease with which they can be co-opted and/or lose their identity as a consumer. Some authors suggest that consumers may become contaminated by the forces of the agency or professional culture leading to a desire for movement towards professionalism and away from their identity as consumers and role in consumer advocacy (Mayer, 1972; Moxley & Mobray, 1997). Consumer-providers may at times “feel isolated, discounted, and pressured to conform by their non-consumer co-workers” (Fisher, 1994, p. 72). In an effort to “fit in”, consumer-providers being to “speak the language of professionals, and trade clienthood for professionalism” (Shepard, 1992, p. 4).

Internalized oppression may also be a barrier for the consumer-provider in maintaining their consumer identity within their role as a service provider. Because of their immersion in the mental health system, consumers have

repeatedly heard criticism from professional staff about the capabilities of consumers. They have been taught to believe that because of their psychiatric diagnosis, they are “incapable of making decisions for themselves and incapable of building close relationships with others” (Levin, 1997, p.362).

To help maintain their consumer identity, it is suggested that consumer-providers continue contact with other consumers, with people and literature from the consumer/survivor movement, as well as establish a clear set of consumer-provider goals and philosophies in writing (Fisher, 1994). The literature also suggests it is ideal to hire multiple consumer-providers or at least to provide opportunities to form interpersonal connections with others who might understand best what they are experiencing (Fisher, 1994; Griffin-Francell, 1997).

Organizational Culture

The culture of the organization can dramatically impact the success or failure of consumer-provider initiatives (Shepard, 1992; Moxley & Mowbray, 1997; Jonikas, et al, 1997; Carling, 1993). A work environment that supports its workers, values diversity, and nurtures open communication can better facilitate integration of consumer-providers into the workplace. Strong leadership is critical to positively impact the work culture by fostering empowerment, communicating with staff the value of pro-consumerism and anti-stigmatization as well as expanding opportunities for consumers in the mental health system (Mowbray & Moxley, 1997).

To promote the success of consumer-provider inclusion, an analysis of the agency's work environment needs to be conducted "in order to identify obstacles to and support for the integration of peer providers" (Jonikas, et al, 1997, p.421). Jonikas et al., suggests that the agency should conduct an assessment that includes the following:

1. Ascertain the goals of the agency in regard to the inclusion of consumers as service providers.
2. Make certain that policy and procedures of the agency are reviewed and updated to support and promote consumer inclusion.
3. Evaluate how the agency has progressed in accomplishing consumer inclusion goals.
4. Evaluate how staff members perceive the consumer hiring initiative and how well they comprehend it.

The initiation of such an agency assessment mandates participation by all staff working for the agency, including consumers and the Board of Directors. Without a strong commitment for change from all key players in the organization, consumer inclusion will not see fruition. Such assessments will typically mandate change both at the individual and organizational levels to reach the goals set forth for consumer inclusion.

Stigmatization

The literature on stigmatization, as it relates to consumer-providers, has been a frequent topic of discussion (Fisher, 1994; Solomon, 1994; Shepard, 1992; Cavanagh-Daley, 1997; Miya, et al, 1997). It is not uncommon for

consumer-providers to feel stigmatized by both non-consumer providers as well as by the consumers they serve. “Clinicians and others who are frequently involved in diagnosing and looking for symptoms, continue to do so in the working environment” (Shepard, 1992, p. 3). For example, there is a tendency on the part of many professionals to interpret difficulties in terms of role performance in terms of the person’s illness e.g. their delusions, paranoia, etc. rather than viewing difficulties as a normal part of working. Stigmatization can occur by labeling persons with disabilities. It is understood that language can be powerfully detrimental and as such, it is imperative that co-workers be particularly sensitive to offensive terms and therefore refrain from using them in any context (Shepard, 1992). For example, some individuals may even experience stigmatization with the label of “consumer-provider” (Solomon, 1994).

In addition to feeling stigmatized by professionals, some consumer-providers may feel stigmatized by other consumers. Consumer-providers may face the pressure of being the role model for the consumer experience as well as being the representative of the target population (Solomon, 1994).

The literature recommends a variety of strategies for organizations to combat the stigmatization of consumer-providers. These strategies include:

- Providing training to help staff members identify and avoid negative stereotypes in the workplace (Shepard, 1992).
- Consciousness-raising through training, exercises, and discussions in administrative and staff meetings, board meetings, and community meetings (Jonikas, et al. 1997).

- Gaining clear support from top administration and work to create a culture in the employment setting that values diversity, past experience, equality, personal honesty, and outcomes, and includes everyone in the process (Miya, et al. 1997).
- “The agency should promote team work, valuing each individual and the knowledge they have gained through personal life experience, role flexibility, and the expectation that everyone can learn from each other” (Miya, et al. 1997, p.343).

Supports & Accommodations

Supports

Peer support is critical to the development and sustenance of consumer-providers in mental health services (Zipple, et al. 1997). Many consumers are reluctant to take on the challenge as provider of mental health services because they may have to surrender peer supports that are established with other consumers (Wilson, Mahler & Tanzman, 1990). One program reported that consumer-providers who sought support from other consumer-providers had difficulty due to the limited number of consumer-providers employed at the agency (Dixon et al., 1994).

It is desirable to include more than one consumer on a team, so that a natural support system is established (Solomon, 1994). An additional mechanism for support is to have connections with the “self-help movement”. This may assist consumer-providers to retain their roots as users of the mental health

system and provide peer support (Shepard, 1992). Finally, another option is to develop peer-led, in-house support groups (Zipple, et al, 1997).

Job coaching is valuable for some consumer-providers (Weklar & Parker, 1997). The job coach assists the consumer-provider to adjust to work demands, provides guidance and feedback on problem areas, and facilitates in the development of strategies to anticipate and deal with problems as they occur. A job coach can also act as a liaison with a consumer-provider's supervisor (Kerouac, 1997).

Mentorship and the personal support of friends, family, supervisors, university staff, colleagues, is also viewed as important to the success for professional development of consumer-providers (Mowbray & Moxley, 1997). In a project that trained consumers to be case management aides, support systems were considered to be an important part of the program (Sherman & Porter, 1991). Such support systems were expressed through a weekly "support group" for the consumer-providers. Over time these formal support structures were replaced by more natural supports such as supervisors and coworkers who later became the primary sources of support.

Accommodations

Reasonable accommodations under the Americans with Disabilities Act (ADA), 1990 must be adhered to by programs employing consumers, and the literature recommends that agencies have established procedures to ensure against discrimination and allow for reasonable accommodations (Dixon, et al, 1994; Jonikas, et al., 1997; Carling, 1993). However, many consumers may be

reluctant to request reasonable accommodations in the workplace for fear of stigmatization (Shepard, 1992; Zipple, et al., 1997). Disclosure under the ADA is voluntary. However, the act of disclosure becomes an asset for agencies, employees, co-workers, and clients in changing attitudes within mental health organizations (Carling, 1993).

Accommodations are as varied as the workers involved. They should be highly individualized and demand that the agency be creative and flexible (Zipple, et al., 1997). Should the consumer-provider experience relapse, it is encouraged that a plan of action should be readily available to prevent the other team members from feeling burdened and resentful (Fox, et al., 1994).

Examples of accommodations include: 1) opportunities to participate in a peer support group (Fisher, 1994); 2) permission for telephone calls to support services during working hours (Shepard, 1992); 3) the use of job sharing and part-time positions; as well as 4) the support for individually tailored transitions of consumer-providers into full-time jobs (Zipple, et al.).

Furthermore, training is recommended for all staff members in the areas of disabilities to sensitize people about the function and necessity for reasonable accommodations (Shepard, 1992).

Consumer Provider Recruitment

According to Zipple, et al. (1997), recruitment of consumers for work in mental health systems must be conceptualized as an ongoing process. Zipple and associates further contend that recruitment can be an arduous task for

several reasons, and to successfully recruit consumers, mental health systems must be keenly aware of these potential barriers:

- 1) Consumers may be suspicious of the organization's motivations or the level of commitment from the organization.
- 2) Consumers may have few role models to demonstrate that employment is both conceivable and rewarding.
- 3) Some consumers have brief or no employment history and the idea of employment may be intimidating.
- 4) Routine hiring policies at agencies such as background checks for all prospective employees may cause stress to the prospective consumer-provider.

In many programs, recruitment practices focus on hiring consumers for existing open positions within the mental health agency (Zipple, et al., 1997). Various avenues for recruitment have been used including: the University (Dixon, et al., 1994), consumer self-help groups, empowerment groups, chapters of the Alliance for the Mentally Ill, agencies serving homeless individuals, and vocational service providers (Zipple, et al., 1997). Zipple, et al., (1997) suggests that building relationships with the above mentioned groups can help disseminate information about open positions and increase an agency's ability to recruit.

Training

For consumer-providers to be effective and successful, the literature suggests that it is critical to provide extensive, relevant training (Fox & Hilton, 1994; Zipple, et al., 1997). An important benefit of training is increasing self-

confidence and morale of consumer-providers by applying learned skills to consumer/clients and their situation. Boykin (1997) describes her experiences as a consumer-provider and reflects on the importance of training. "Training...has given me the confidence and ability to provide the best assistance possible to my peers...with training and experience I am now able to set limits more effectively" (p. 381).

A literature review provides some examples of training for consumer providers.

- Consumer-providers participate in the Office of Mental Health sponsored training provided to all case managers in the system. Training includes an orientation to severe mental illness, treatment indicators, and case management functions. Training also includes periodic continuing education sessions. In-service training and periodic continuing education sessions are also offered to increase case management clinical skills" (Solomon, et al., 1997).
- Pairing new consumer-providers with life skill consultants whose consumer/clients the consumer-provider would most likely respond to (Hildebrand, et al., 1997).
- Providing extensive training for all staff (including consumer providers), including eleven full days of training during staff's initial 60 days of employment (Zipple, et al., 1997).
- Denver's case management aid training program consisted of six weeks of formal classroom training, 50 lab hours practicing work skills

with each other in the classroom, and 300 hours (14 weeks) of on-the-job training. Classroom instruction included 45 hours of direct skills training (stress management, study skills, cognitive training), 45 hours of interviewing, acquiring benefits, identifying deficits in independent living skills, and transportation logistics, and 30 hours on case management and crisis intervention (Sherman & Porter, 1991).

Supervision

Receiving good supervision from a skilled and knowledgeable supervisor is perceived as important in the hiring of consumers in the role of service providers (Zipple, et al., 1997; Griffin-Francell, 1997). Developing skilled supervisory staff and having strong commitment within the organization is a necessary component for the success of hiring and maintaining consumer employees.

The relationship between the consumer-provider and the supervisor is seen as critical (Jonikas, et al, 1997). The supervisor should have an appreciation of the challenges faced by consumer-providers, and be understanding, supportive, and want the consumer-provider to succeed (Shepard, 1992; Zipple, et al, 1997). Supervisors can reframe failures for the consumer-provider and assure them that they will be successful (Griffin-Francell, 1997). Placing consumer-providers “under the supervision of an authoritarian, perfectionistic, or unrealistic person is a recipe for failure” (Griffin-Francell, 1997, p. 474). The literature further suggests that supervisors themselves may need additional support and technical assistance given that consumer provision of

mental health services is a relatively recent phenomenon and as such, supervisors may experience difficulty (Weklar & Parker, 1997; Zipple, et al., 1997). Fisher (1994) believes that only other consumers should supervise consumer-providers.

In a study of consumer-providers working in an ACT Team, supervision was directed at helping the consumer-provider make decisions about which clients need their time and resources (Dixon et al., 1994). In this study, supervision discussions focussed on the types of interventions used by the consumer-providers, whether or not the interventions were working and alternative strategies the consumer-provider might try.

The supervisor can also be helpful in responding to non-consumer providers' attitudes toward consumers working in the agency. "The supervisor was instrumental in helping the consumer-provider's co-workers to examine their professional sensitivity and to be responsive to the consumer point of view" (Weklar & Parker, 1997, p. 394).

Dealing with Illness. Supervisors encounter employees who are ill regardless of whether it is psychiatric or physical. The agency must establish a standard response to illness (Solomon, et al., 1994). In the case of consumer-providers, Solomon and associates provide strategies to deal with a consumer-provider's illness.

- 1) Agencies must accept a wider range of acceptable behavior in the workplace due to the diverse nature of employees hired in mental health.

- 2) Many agencies confront the difficulty of discerning when behavior is “symptomatic”. “Supervisors must take into account the context in which the behavior is occurring” (p. 49). What may be considered a strange or unusual behavior in one situation may be appropriate in another.
- 3) However, if an agency denies the strange and unusual behavior of a co-worker, such denial can be detrimental to the consumer-provider. It is important to recognize that some consumer-providers encourage a straightforward approach and thus welcome feedback.
- 4) If a consumer-providers’ behavior is disruptive to the agency, one option for the supervisor is to request the individual to take a leave of absence. Assurance that the consumer-provider is not being fired must be provided. In addition, assistance to the consumer-provider can be offered.
- 5) If a consumer-provider is asked to take a leave of absence, help the consumer-provider prepare for their return by making plans before he or she leaves. This includes discussions surrounding the expected length of the leave, how to respond if more time is needed, and how the leave should be explained to other staff.

Confidentiality

There are numerous dilemmas related to confidentiality when a consumer becomes a provider of mental health services. The dilemmas are heightened

when the consumer receives services in the same agency in which he or she is working.

First there is the need to respect the privacy and confidentiality of the consumer-provider. If the employee discloses that they are a consumer or information about their illness, there is much contemplation on whether that information is shared, how is it shared, and to whom (Zipple et al., 1997). An example of the difficult nature of disclosure arises when a consumer-provider experiences exacerbation of their illness or needs hospitalization. If a consumer has not disclosed information about their psychiatric disability, confusion or misunderstandings on the part of supervisors and co-workers may arise. If the consumer-provider has disclosed only to their supervisor, questions surrounding accommodations or a leave of absence could arise from other staff (Zipple et al., 1997; Solomon et al., 1994). Recognizing disclosure is a highly individualized decision, Zipple et al. (1997) recommends consumer-providers are open about their psychiatric disability to their supervisor as well as to the organization as a whole.

Another issue regarding confidentiality is the consumer-provider having access to confidential information either through access to case files or through conversations individually or in team meetings. Consumer-providers may have past or current friends in services and have access to treatment information about them (Curtis & Hodge, 1994). There can also be concern about breaching confidentiality. The consumer-provider may divulge information about service

recipients outside of the agency due to the lack of knowledge about the mandates for confidentiality (Solomon et al., 1994).

Some of the literature suggests that the consumer-provider, as a staff member, should be expected to adhere to the same principles of confidentiality that all team members abide by (Fox & Hilton, 1994; Dixon, et al., 1994). Solomon et al. (1994) suggest that consumer-providers may not have obtained formal training on the importance of confidentiality and recommends that agencies provide all staff with clear written protocols and training on confidentiality. Solomon and colleagues also suggest that written protocols include who can have access to case records and under what circumstances.

Consumer-providers may have also been in services at the same time as some of the people with whom they are working. Due to their prior relationship with a client, they may be privy to information that the service providers do not know and the client does not want them to know. Solomon and colleagues (1994) suggest in these cases, "information gained through such interactions is confidential and should not be revealed to other staff even if it is potentially important to the clinical process" (p. 57).

All of the above mentioned dilemmas regarding confidentiality are barriers to hiring consumers as providers in community support programs. Zipple et al. (1997) discuss the way hospitals and health maintenance organizations (HMOs) have faced these challenges and developed mechanisms to deal with confidentiality issues. Zipple et al. (1997) states, "It is our belief that facing these challenges... is an aspect of reasonable accommodation and that providers who

refuse to hire categories of employees because of their concerns related to privacy and confidentiality may be in violation of the Americans with Disabilities Act” (p.417).

Conclusion

There are numerous barriers identified in the literature in which the mental health system must overcome. The barriers unique to consumers include the consumers’ need to maintain their identity and roots as a consumer, stigma and the decisions and difficulty consumer-providers may have with non-consumer professionals due to their unique perspective and experience of the system and the illness. Consumer-providers also can face unique barriers in obtaining special supports and accommodations for the workplace. For these barriers unique to consumers, we must address the stigma and fear that exists within our own agencies. We must also learn to accommodate and support consumer-workers as we expect community employers to do so.

There are, however, many barriers for consumers working as providers in the mental health system that are not unique to consumers. All employees require excellent supervision tailored to individual circumstances. Hiring is a risk at any time. Any employee may be challenging and difficult. Non-consumers may have illness that requires blocks of time off or special allowances for visits to the doctor. Dual relationships not only occur for consumer-providers, but also can happen to non-consumer providers who may have family members or friends in services. Professionals in rural areas are consistently faced with difficulties related to dual relationships. There can always be the fear of breach of

confidentiality with entry level workers such as attendant care or assistant case managers who may not have had extensive training and lack the professional alliances that hold them to standards of ethics. Stigma can still occur for minorities. Role conflict and confusion may occur for any employee in an agency that lacks clear job descriptions, goals, training and role expectations. Organizational cultures may be “unfriendly” to all workers, not just consumer-providers. Closed, rigid, punitive agency work environments can negatively impact any employee. It appears that the key to overcoming the barriers to consumers working as providers largely has to do with stepping back, and normalizing the experiences they may face. It is then that we may take the risk to hiring people with serious psychiatric disabilities and bring a unique perspective and diversity to our work force.

Chapter 2

Summary of Benefits

The following is a summary of the benefits of hiring consumers as providers from the review of the literature. These include benefits to the consumers receiving services, benefits to the consumer-provider, and benefits to the mental health system.

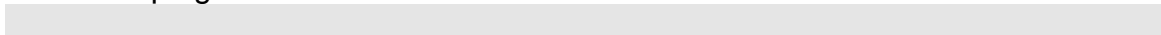
Benefits to the consumers receiving services

- Desirable attributes of consumer employees include systems knowledge, “street smarts”, responsiveness, coping strategies, patience & flexibility, relational emphasis, issue identification, engagement abilities, role modeling, information & referral, advocacy against stigmatization, and educational activity with co-workers.
- Consumer providers, by virtue of the position they have reached, instill hope. Hope, not only to the consumer provider, but also to the consumers who receive services.
- In a study of the effectiveness of consumers as providers, there was no statistical difference in the outcomes at one year and two years of clients served by consumer-providers and non-consumer providers (Solomon & Draine, 1995a; Solomon & Draine, 1995b).
- Studies also showed consumer-providers as having more interpersonal contact with clients than non-consumer providers (Solomon & Draine, 1996a) and more likely to provide face-to-face service contact with clients than non-consumer providers (Solomon & Draine, 1996b).
- Lyons, Cook, Ruth, Karver & Slagg (1996) found that consumer staff engaged in more street outreach.
- Consumer providers bring their unique perspective to service delivery from someone who has likely had similar experiences and have special knowledge and skills as a result of their personal experience of the illness and the mental health system.
- Hiring a person with a psychiatric disability can serve as a powerful role model for individuals served by their respective agency.

Benefits to the Consumer Provider

- Working as a provider empowers consumers by increasing their sense of value and self worth as well as providing avenues for personal growth and development.
- Fifteen case management aids who were still employed after a two year period had only required a total of two bed-days of psychiatric hospitalization since the training ended (Sherman & Porter, 1991).
- A study of consumer case managers found that there were no greater signs of stress, decreased self-esteem or burnout among the consumer providers compared to the non-consumer providers (Solomon & Draine, 1996).
- One study reported personal growth, increased self-confidence, and developing specific skills for consumers assuming the role of provider (Mobray, Moxley, Thrasher, Bybee, McCrohan, Harris & Clover, 1996).

Benefits to the System

- Consumer-providers can educate staff and administration and heighten staffs' awareness and sensitivity to the struggles faced by consumers.
 - The hiring of consumers adds a different perspective, brings understanding and diversifies the work environment.
 - The practice of hiring consumers conveys to workers that consumers are important, they are capable as human beings, and bring valuable experience to the work.
 - Consumer providers significantly impact an agency through the increased likelihood that the consumer voice is integrated in planning, evaluating and developing services.
- 

Chapter 3

Summary of Challenges and Possible Solutions

This chapter summarizes the barriers and strategies for overcoming obstacles found in the review of the literature and identified in the two Consumer-Provider Forums. The following is an overview of the challenges and solutions discussed in this chapter and the page numbers where they may be found.

Dual Relationships	Page 41
Confidentiality	Page 44
Role Conflict and Confusion	Page 47
Providers Maintaining Their Identity as Consumers 50	Page
Organizational Culture	Page 51
Stigmatization	Page 52
Supports	Page 55
Accommodations	Page 55
Consumer-Provider Recruitment	Page 57
Hiring	Page 58
Training	Page 60
Supervision	Page 61

Dual Relationships

Summary of the Barriers:

Barrier 1 - Centers not hiring consumers who are receiving services from their respective agencies due to the heightened ethical dilemmas surrounding dual relationships.

- Consumers may be forced to disrupt services and relationships that have helped to enhance and maintain the progress they have made. Disruption of such services can lead to major setbacks in their recovery.
- In smaller rural communities, consumers usually do not have alternative access for services in their area. Therefore, changing service providers becomes problematic due to the long distances between service provider agencies.
- Professionals' fear of the risks associated with dual relationships such as losing their professional license. Issues associated with this fear include:
 - ❑ Dual relationship is defined in different ways (e.g. just having a dual relationship versus dual relationship with risk of exploitation & harm)
 - ❑ Policies for professional code of ethics are not specific about dual relationships other than with regard to money and sexual relationships.
 - ❑ There is a disparity in values as seen in the culture and attitudes of agencies and the state between supporting and wanting to move toward hiring consumers and the lack of supportive policies and information for hiring consumers as providers.
 - ❑ The State Department of Mental Health & the Association of Community Mental Health Centers do not give their support for or have a position on dual relationships.

Barrier 2 - If a consumer-provider currently (or in the past) receives services at the same agency in which they work, it is not clear what their relationship with consumers with whom they are friends can be.

Possible Solutions for Dual Relationships

Considerations

- We need to recognize that there are multiple relationships that exist in life, particularly in rural settings.

- When looking at risk of harm to consumer (when the consumer-provider is receiving or has received services at the agency in which they are employed), the risk to the center or the risk to the consumer is less than the benefits gained by the opportunity to be employed.
- It seems to be unethical to not provide case management services to the consumer-provider, when the center is the only provider in the area.
- Agency staff should not be guided by arbitrary distancing and noninvolvement rules, but must make such determinations on an individual basis. Since there are many differences between people and agencies, there needs to be flexibility in the policies and rules around dual-relationships and role conflict.

1. Develop guidelines and policies addressing dual relationships.

Example policies include:

A. Sample Policies for Mental Health Centers for the consumer-providers' relationship with consumers of the agency

Policy a: Provide training to staff (both consumer-providers and non-consumer providers) in mental health agencies on confidentiality, boundaries, and roles to discuss and clarify each area.

Policy b: The consumer provider cannot directly serve people with whom they have or have had a friendship with.

Policy c: The consumer-provider cannot be on the same team serving a person with whom they have a personal relationship.

Policy d: (For consumer-provider working in an attendant care or respite program) Regarding responding to situations in which friends of the consumer-provider may enter services: If the consumer-provider has knowledge of a potential conflict in relationships, they will talk with their supervisor and not work with those consumers.

Policy e: Regarding the consumer-provider obtaining information he/she learns from the community (e.g. from friends, acquaintances, etc.): If the consumer-provider learns information about a client-friend in the community that poses a threat to self or others, they have the obligation to report that information to their employing agency. Any other information, that does not pose a threat, can be kept confidential.

B. The service providers/employers relationship with the consumer-provider

Policy a: Those relationships existing before a consumer became part of the staff team are allowed to continue, but the consumer provider is not able to provide any services or be in any kind of supervisory position over the other person.

Policy b: The supervisor and consumer may not have a past treatment relationship and the supervisor should relate to the consumer only as an employee/ The consumer-provider may not be under the direct supervision of the person with whom they have had a present or past treatment relationship.

Policy c: The consumer-provider may not receive services by the agency in which they are working - either hire from outside of the agency or insist that the consumer provider hired from within their agency transfer service to another agency. (note – this policy excludes many agencies from hiring due to the limited choices of other providers or consumers not wishing to change services)

Policy d: Hire consumers and find alternative ways to provide services to consumer-providers such as:

- ❑ Develop exchange program with other agencies e.g. developmental disabilities programs
- ❑ Use of telemedicine/teleconferencing with their service provider
- ❑ HMO's
- ❑ Other departments providing the service
- ❑ Consumer Run Organizations providing the service

Policy e: Part-time consumer-providers can receive services through the center, but full-time employees need to receive services elsewhere, if possible.

Policy f: An agency can hire consumer-providers receiving services from the agency if the consumer-provider is in a different department, team, or service program than their treatment providers.

Policy g: The center will provide informed consent regarding employment of consumer-providers if there is no option for a consumer-provider to receive services elsewhere (due to lack of alternatives, distance, or harm to consumer). The employing agency may employ the consumer by using informed consent of the potential conflicts and difficulties that may arise with the consumer being an employee and a client of the agency.

2. Agencies should facilitate discussions concerning dual relationships within the work setting.

Confidentiality

Summary of Barriers:

Barrier 1 - The privacy and confidentiality of the consumer provider (which is more difficult when the consumer receives services in the same agency in which he or she is working). E.g. sharing information about their illness, accommodations, and times the consumer-provider may experience exacerbation of their illness or need hospitalization

Barrier 2 - The consumer provider having access to confidential information (on past or current friends) either through access to case files or through conversations individually or in team meetings.

Barrier 3 - The consumer provider breaching confidentiality by divulging information about service recipients outside of the agency due to the lack of knowledge about the mandates for confidentiality.

Barrier 4 - Consumer providers may have also been in services at the same time as some of the people with whom they are working. Due to their prior relationship with a client, they may be privy to information that the service providers do not know and the client does not want them to know.

Barrier 5 - Lack of training about confidentiality, boundaries, and other policy issues.

Potential Solutions for Confidentiality

Discussion Regarding Dual-Relationships and Confidentiality:

Consumer-providers should be able to sustain prior friendships with other consumers. At the same time, they need to be clear about the boundaries between work and their friendships with their peers. The difficulty involved with confidentiality depends greatly on how intimate the friendships and the type of work performed in the mental health setting. For example confidentiality is far more difficult when a consumer-provider is a case manager has a very close friend in the program versus when a consumer-provider is an attendant care worker and one of their clients is a casual acquaintance.

There need to be policies that help consumers separate between their personal life and work, and what can be shared when. However, many times there is often a judgement call involved along with gray areas that can't always be dictated by black and white policies. Policies and guidelines should be as clear

as possible, not ambiguous, and should be combined with open discussions of boundaries with team, supervisor, and/or agency for the purpose of lending clarity to the consumer-provider's role and problems associated with confidentiality.

The following are suggested ways to handle dilemmas surrounding confidentiality:

Confidentiality of Program Clients (particularly with friends who may also be service recipients of the program)

1. The consumer provider, as a staff member, should be expected to adhere to the same principles of confidentiality that all team members abide by
2. Consumer-providers obtain formal training on the importance of confidentiality and agencies provide all staff with clear written protocols and training on confidentiality. Written protocols include who can have access to case records and under what circumstances.
3. **Policy:** Consumer-providers may socialize with consumers they have had prior friendships with, but they must not talk about work-related issues or clients. The consumer-provider should talk with their friends who are clients in a program in which they work about their need to keep information confidential and the fact that they can not share information about work or clients.
4. If the consumer provider has had a prior relationship with a client and are privy to information that the service providers do not know and the client does not want them to know, the information gained through such interactions is confidential and should not be revealed to other staff even if it is potentially important to the clinical process.
5. The consumer-provider must make clear with friends and acquaintances that are also service recipients of a program that certain information that is divulged to the consumer-provider would have to be shared with the agency.
 - a. Information that is life threatening, if shared with the consumer-provider, must be shared with the agency. Life threatening is defined as any expressed desire to harm oneself or others, either verbally or in writing.
 - b. If the information provided by a friend or acquaintance to the consumer-provider is not life threatening, but is information that may be helpful for their service provider to know, the consumer-provider is not obliged to share the information with the agency. The consumer-provider may make suggestions to their friend or acquaintance that they discuss the information with their case manager or other treatment provider.

6. Provide consumer-providers opportunities to talk about difficult situations regarding confidentiality and relationships with others i.e. with their supervisor, mental health team and/or peer support group.

Confidentiality of the Consumer-Provider

1. Some consumer-providers feel comfortable with their consumer-provider status being known. Other consumer-providers do not like to be known as the “consumer” provider. The agency should talk with the consumer-provider initially to find out who may have knowledge of their status under what circumstances. Respecting the privacy of the consumer-provider over-rides the desire and pride to “advertise” the hiring of consumers as providers. In any event, the consumer-provider is a provider first and should be thought of and discussed as such.
2. Regarding Hospitalization: The possibility of someone becoming ill and needing hospitalization should be discussed at the beginning of employment. There should be an agreement between the center and the employee of how to handle situations in which the consumer-provider becomes ill including: What if people notice signs of decompensation? Who does the consumer-provider want notified if they become ill? What do they want said to staff and clients if they are hospitalized? If an agency becomes more aggressive in its involvement in the need for hospitalization of a consumer-provider, it must be related to the consumer-providers’ work performance, not just that they heard they went off their medications or they are not looking as well, etc.

Confidentiality Related to the Agency

1. At times, there may be agency “secrets” such as changes to be made in the agency, problems, etc. Keeping these “secrets” may be difficult for any staff or supervisor, not just consumer-providers. It is preferable that the agency has an organizational culture that is as open as possible and keep agency “secrets” at a minimum. If a consumer-provider has difficulty with an agency “secret”, it is suggested that the person take some time and confer with someone who’s judgement they trust about what to do if they are uncomfortable with an agency “secret”.

Role Conflict and Confusion

Summary of the Barriers:

Barrier 1 - The existence of role confusion or power struggles between consumer and non-consumer providers

- There is discomfort on behalf of non-consumer providers that evolve from the difficulty in accepting consumer providers as equals.
- **There is discomfort for consumer-providers balancing their consumer identity and their new professional identity**

Barrier 2 - Often times, the roles and responsibilities of consumer providers in the workplace can be vague - role expectations and job duties can be unclear which lead to ambiguity in the work.

Barrier 3 - Confusion on the part of the consumer-provider as to why they represent the clients or the agency and their role in advocating for the consumer served.

Barrier 4 - Information gained through a relationship with a peer/friend who is also a client, particularly with regard to safety issues. Does the consumer-provider have the obligation to tell the center? **(See dual relationship #1A. policy e)**

Barrier 5 - The consumer-provider not knowing what to do when they see something unjust happen to a consumer by the agency.

Possible Solutions for Role Conflict and Confusion

Discomfort on behalf of non-consumer providers that evolve from the difficulty in accepting consumer-providers as equals.

1. Agencies create a consumer-provider friendly organizational culture by:
 - ❑ Providing training on stigmatization
 - ❑ Encouraging that consumer and non-consumer providers participate in social/fun things together
 - ❑ Consumer-providers call non-consumer providers by first name
 - ❑ Provide sensitivity training for staff (include office/clerical staff)
 - ❑ Provide training to help centers be more friendly, respectful to all consumers

- Make evaluations a positive tool for career development rather than a punitive tool by documenting consumer-provider work success', accomplishments and achievements.

Discomfort of consumer-providers balancing their consumer identity and their new professional identity

1. The agency provides explicit and concrete guidelines about staff activities with clients, giving examples.
2. The agency/supervisor allows consumer-providers equal opportunities to vent as are given to other staff (without the consumer-provider being seen as "crazy", "symptomatic" or without fear of repercussions).
3. Agency supervisors normalize consumer-provider reactions to situations and give this feedback to staff.
4. The agency and staff respect the right for the consumer-provider to disclose, not to disclose, or how much to disclose about their disability.

Role expectations and job duties can be unclear and ambiguous.

1. The agency provides clear job descriptions that delineate roles and responsibilities.
2. As a routine part of training, staff, including consumer-providers, shadows a more experienced person.
3. It is critical that all staff, including consumer providers, have on-going supervision to review their work.
4. There is a thorough, clear orientation to center policies including discussion groups and opportunities to ask questions.
5. Set up role expectations and interactions with co-workers such as:
 - The consumer provider is as accountable to the team as any other member,
 - The consumer provider is expected to bring all relevant information to other team members,
 - Provide direct supervision assisting the consumer-provider in discerning what information to share with the rest of the team.
6. Facilitate communication and dialogue about role confusion with all people involved.

Confusion on the part of consumer-providers as to whether they represent the clients or the agency and their role in advocating for the consumer served.

1. The employing agency needs to acknowledge that this is a dilemma for all staff.
2. The agency provides forums for discussion on the delicate balance staff may face in being an advocate for the client and a representative for the agency, particularly when there is a disagreement between the two. Recognize that balancing the two may be a matter of trial and error, and have opportunities for staff to process these struggles in supervision.
3. The agency has a grievance process in place for when there are disagreements.
4. Consumer-provider can organize associations or networks or consumer-providers can join a professional association for avenues to discuss dilemmas related to conflicts in advocating for clients when it conflicts with agency policy.
5. The consumer-provider is encouraged and provided with opportunities to discuss dilemmas with other consumer-providers at the same agency.

Differences and conflicts in the way consumer-providers and non-consumer providers view good services.

1. There are mechanisms for advocating and being a part of systems change within an agency.
2. Consumer-providers assertively advocate on behalf of the client to the team or agency, but respect the team decision process.
3. The MHC provides training to center staff, including consumer-providers, in conflict resolution and mediation skills.
4. Consumer-providers provide support to other consumer-providers working in the system.

Providers Maintaining Their Identity as Consumers

Summary of Barriers:

Barrier 1 - Consumer-providers can be co-opted and/or lose their identity as a consumer. Consumers may become contaminated by the forces of the agency or professional culture leading to a desire for movement towards professionalism and away from their identity as consumers and role in consumer advocacy.

Barrier 2 - Internalized oppression may also be a barrier for the consumer provider in maintaining their consumer identity within their role as a service provider.

Possible Solutions for Maintaining Identity

1. Consumer-providers continue contact with other consumers, with people and literature from the consumer/survivor movement, as well as establish a clear set of consumer-provider goals and philosophies in writing.
2. Hire multiple consumer providers or at least to provide opportunities to form interpersonal connections with others that might understand best what they are experiencing.
3. Provide peer support groups for consumer-provider to get support, feedback and ideas.
4. The agency should promote the idea that “consumer identity” is important by:
 - Promoting normalizing activities that involve consumers and staff (social events).
 - Provides education to staff around the historical perspective and oppression of people with a mental illness.
 - Embracing and asking for the client voice/advocacy in team meetings.
5. Providing opportunities for consumer-providers to network with each other including:
 - Peer role models from other agencies relating their experiences with consumer-providers.
 - Holding a consumer-provider conference.
 - Developing a consumer-provider organization.
6. Approaching the hiring of consumers as providers as a part of increasing diversity in the work force in order to increase the variety of different viewpoints workers bring to the agency.

7. Centers have a policy to hire/recruit consumers to hold positions at multiple levels of the organization.
8. Agencies provide opportunities and include consumers in the decision-making of the organization.

Organizational Culture

Summary of Barriers:

Barrier 1 - Organizational work environments can be “unfriendly” to consumer-providers e.g. closed communication, rigid, stigmatizing, etc.

Possible Solutions for Organizational Culture

- Create a work environment that supports its workers, value diversity, and nurtures open communication can better facilitate integration of consumer providers into the workplace.
- Provide strong leadership to positively impact the work culture by fostering empowerment, communicating with staff the value of pro-consumerism and anti-stigmatization as well as expanding opportunities for consumers in the mental health system.
- Analyze the agency’s work environment in order to identify obstacles to and support for the integration of peer providers. Such an agency assessment should include participation by all staff working for the agency, including consumers and the Board of Directors. The assessment should include the following:
 - ❑ Ascertain the goals of the agency in regard to the inclusion of consumers as service providers.
 - ❑ Make certain that policy and procedures of the agency are reviewed and updated to support and promote consumer inclusion.
 - ❑ Evaluate how the agency has progressed in accomplishing consumer inclusion goals.
 - ❑ Evaluate how staff members perceive the consumer hiring initiative and how well they comprehend it.

Stigmatization

Summary of Barriers:

Barrier 1 - Consumer-providers may feel stigmatized by “professional” staff.

- Consumer-providers feel uncomfortable when treatment providers discuss the consumer-provider with their supervisor.
- Professionals are not able to see variations in the sick-well continuum.
- Professional staff over-reacting when the consumer-provider gets sick.
- Double standard - what is OK for professionals is not OK for the consumer-provider.
- Professionals disempowering consumer-provider by squelching advocacy efforts, making “put-down” or derogatory remarks.

Barrier 2 - Consumer-providers may feel stigmatized by the consumers they serve.

- MH Clients’ discomfort with consumers as providers – lack of trust or confidence in consumer-providers’ ability.
- Consumers of services not able to see variations in the sick-well continuum.
- There is awkwardness when a consumer-provider gets treatment where the consumer-providers’ clients also get treatment.

Barrier 3 - Consumer-providers may have their own internalized stigma.

Possible Solutions for Stigmatization

Stigma by the Consumer(s) Receiving Services

1. To help the consumer provider be seen as an equal to any other employee by the consumers served:
 - The agency can stress the employee over consumer aspect of the person in relation to their job.
 - The agency can make special efforts to embrace the person as an employee who is competent as any other employee in their same position.
 - The agency can adopt an organizational culture that fosters consumer empowerment and consumers’ capabilities. The agency can do this by such things as more client-run activities, fewer rules, emphasis on consumers’

ability to work in many settings, fields, etc. These activities institutionalize the belief that consumers are capable.

- The agency can provide the consumer-provider with a lot of support and encouragement that compensates for the discouragement and fear they may feel from those consumers served who feel they are not good enough due to their consumer status.
- The consumer-provider could have an open, frank discussion with a consumer who is reluctant to work with the consumer-provider.
- The agency can promote an accepting and non-stigmatizing view of hospitalization (i.e. that it is part of a process) so that the consumer-provider who may be hospitalized would feel less stigmatized.

Stigma by Staff and Agency Personnel

1. Hire more than one consumer-provider in an agency so that in individualized situations where a CP might not perform well, there are not generalizations made by staff that all consumer-providers can not do well in their employment.
2. The agency and supervisor consciously reinforce and emphasize the positives that a consumer-provider adds to the team/agency. One example would be to journal in team meetings the things that the team has done well, positive outcomes, struggles that ended well, and keep them in a place to review and look at regularly.
3. Educating staff plus good experiences with consumer provider increases the organizational culture's acceptance of consumers working as providers
4. Initially hiring consumer-providers with a high degree of competency in order to provide successful experience for those who have difficulty viewing a consumer in the role as provider.
5. Initially hiring more than one consumer-provider so that they may job share and back each other up.
6. Providing training to help staff members identify and avoid negative stereotypes in the workplace and promote consciousness-raising through training, exercises, and discussions in administrative and staff meetings, board meetings, and community meetings.

7. Create an agency culture that combats stigmatization, bias and prejudice by recognizing such prejudices and biases, and addressing it by creating more flexibility in workers roles. **(See also section on organizational culture)**
8. Gain clear support from top administration and work to create a culture in the employment setting that values diversity, past experience, equality, personal honesty, and outcomes, and includes everyone in the process.
9. Promote teamwork within the agency, valuing each individual and the knowledge they have gained through personal life experience, role flexibility, and provide the expectation that everyone learns from each other.
10. Promote tolerance and appreciation for diversity in the workplace by:
 - Acknowledging that conflict is possible, if not likely, and address it directly during orientation and training of new employees. Employers should have clear expectations for employees' respect and acceptance for all individuals.
 - Creating an environment where non-consumer staff feel comfortable discussing their discomfort and difficulties they may experience viewing consumer providers as colleagues.
 - Work with consumer staff to develop an approach that educates and promotes acceptance without breaching their privacy.

Internalized Stigma of the Consumer-Provider

1. Provide a peer support group for consumer-providers.
2. Provide and encourage continuing education for consumer-providers.
3. Assist staff to recognize how difficult it may be for a consumer-provider to voice their opinion, bring an idea to the table, etc. Staff can recognize and show appreciation for the ideas, input, and the contribution consumer-providers bring to the agency/team.
4. The consumer-provider can find a person within the agency that they feel safe with to check things out e.g. "this staff person said this to me which shut me down and made me feel bad. Is this stigma? Is it normal? Should I be concerned?"

Supports

Summary of Barriers:

Barrier 1 - Many consumers are reluctant to take on the challenge as provider of mental health services because they may have to surrender peer supports that are established with other consumers. Some agencies' policies demand that the consumer-provider must leave the consumer culture, their friends, etc. when employed at the agency which interferes with the consumer providers' natural peer supports.

Barrier 2 - Some consumer-providers have difficulty in facing the work demands and need or desire additional supports for work and find the agency does not provide or allow for those supports (peer support, job coaching, extra service support, etc.).

Possible Solutions for Supports

1. Include more than one consumer on a team, so that a natural support system is established.
2. Consumer-Providers to have connections with the "self-help movement".
3. Develop peer-led, in-house support groups.
4. Job coaching is valuable for some consumer providers to assist the consumer provider to adjust to work demands, provides guidance and feedback on problem areas, and facilitates in the development of strategies to anticipate and deal with problems as they occur. A job coach can also act as a liaison with a consumer provider's supervisor.
5. Use of mentors and the personal support of friends, family, supervisors, university staff, colleagues.
6. Over time replace formal support structures with more natural supports such as supervisors and coworkers.

Accommodations

Summary of Barriers:

Barrier 1 - Consumers may be reluctant to request reasonable accommodations in the workplace for fear of stigmatization

Barrier 2 - MHC agencies lack of understanding about reasonable accommodations and ADA, particularly for people with psychiatric disabilities. There is also a lack of policies and supports to assist with reasonable accommodations. The lack of understanding in Kansas CSS' comes from the lack of experience with reasonable accommodations. Some of the questions and difficulties are outlined below.

- What are reasonable accommodations?
- Caring versus stepping over the line to support
- How to make distinction between non-productivity and accommodations
- Staff has difficulty making decisions on accommodations due to lack of clear guidelines and the fact that the ADA doesn't provide guidance
- Who has knowledge of reasonable accommodations for psychiatric disabilities?
- How are accommodations approved?
- How do accommodations get in place?
- How do you know if an accommodation is reasonable?
- Lack of part-time positions or the provision of other accommodations.

Possible Solutions for Accommodations

1. Agencies should have established procedures to ensure against discrimination and allow for reasonable accommodations.
2. Accommodations are as varied as the workers involved. They should be highly individualized and demand that the agency be creative and flexible
3. Should the consumer-provider experience relapse, it is encouraged that a plan of action should be readily available.
4. Examples of accommodations include:
 - ❑ Opportunities to participate in a peer support group
 - ❑ Permission for telephone calls to support services during working hours
 - ❑ Job sharing and part-time positions
 - ❑ Transition of consumer-providers into full-time jobs
5. Training for all staff members in the areas of disabilities to sensitize people about the function and necessity for reasonable accommodations.
6. Agencies provide or have access to training and technical assistance:
 - ❑ Agencies should provide specific training to all staff on the ADA (law) and psychiatric disabilities, including examples of reasonable accommodations.
 - ❑ Training is provided for supervisors on how to work with accommodations.

- ❑ Training is provided to consumers on how, when, and if to ask for accommodations.
- ❑ An ADA manual is available to all agencies that includes a list of resource numbers including state and federal.
- ❑ Designate a staff person who is knowledgeable on ADA in the agency to do training, acts as a resource person for consumer-provider and staff, works with the supervisor and new hires, and reviews/consults on requests for accommodations.
- ❑ After hiring consumer-provider, have written and verbal information on right to accommodation.

7. Inform and educate CMHC legal counsels on ADA and accommodations

8. In order to educate agencies on types of accommodations for psychiatric disabilities, collect ideas of successful accommodations that have been tried/used and share this information statewide. Examples of accommodations include:

- ❑ Have available opportunities to participate in peer support activities & availability to do this during work time.
- ❑ Flexible hours for the consumer-provider that meets the employees needs in conjunction with the needs of the agency and consumers' caseload needs.
- ❑ Provide consumer-providers with opportunities for part-time employment with the ability to transition into full-time and increase hours.

Consumer Provider Recruitment

Summary of Barriers:

Barrier 1 - It is difficult to recruit consumers to work in mental health settings due to the following barriers.

- Consumers may be suspicious of the organization's motivations or the level of commitment from the organization.
- Consumers may have few role models to demonstrate that employment is both conceivable and rewarding.
- Some consumers have brief or no employment history and the idea of employment may be intimidating.
- Routine hiring policies at agencies such as background checks for all prospective employees may cause stress to the prospective consumer provider.

Potential Solutions for Recruitment

1. Building relationships with the following groups can help disseminate information about open positions and increase an agency's ability to recruit - the University, consumer self-help groups, empowerment groups, chapters of the Alliance for the Mentally Ill, agencies serving homeless individuals, and vocational service providers.
2. Advertising and letting consumers know about availability of a position.
3. Agencies letting consumers know that they are welcome to apply and that it is desirable for consumers to be providers.
4. Posting of positions in consumer areas.
5. Current Consumer Providers recruiting others and sitting in on interviews.

Hiring

Summary of Barriers:

Barrier 1 - Cost to Agency. Concern of professionals that consumers use more sick time and are less productive escalating medical and insurance costs because of illness and decreasing productivity. It costs the agency when they need to provide back-up staff coverage for providing services to their caseload when the consumer-provider is gone. There may be resentment from staff of having to find or provide coverage that decreases morale. Less overall funds may be available because of increased costs which impacts competitive salaries, retaining staff, recruitment and raises beyond base salary. The question becomes how is this any different than physical illness of staff, maternity leave, etc.?

Barrier 2 - Fear that the hiring process can impact how a consumer may feel about the MHC and their relationship with the MHC e.g. if a consumer applies and is not hired, anger or resentment toward the center may occur.

Barrier 3 - Failure to recognize life experience as valid education/experience.

Barrier 4 - Loss of benefits (SSI/SSDI) for the consumer-provider

Barrier 5 - Passing over a consumer-provider with training equal to a non-consumer for the non-consumer.

Potential Solutions for Hiring

Considerations

- Consumers, as like all applicants, must meet minimum qualification of the job to be hired. A consumer should never be hired only on the basis that he/she is a consumer.
- Some professionals are concerned that by giving consumers in their centers opportunities to apply for positions, that if they do not get the job, they will be hurt and alienate themselves from services.

Costs associated with consumer-providers (medical, insurance, and productivity).

1. Consumer employees are expected to fulfill job requirements.
2. Agencies should have a clearly defined leave policy.
3. Employer and employee has a plan in place for when consumer-provider needs time off or there is a hospitalization (e.g. what will happen with caseload)
4. Agencies should review their policies for promotion of consumer hiring and retention e.g. family leave act, part-time employee policy, etc.
5. Obtain descriptions of where and how job sharing and part-time job availability has worked to share information statewide.
6. The state provides incentives to mental health centers to hire consumers.
7. Give CMHC's information e.g. Workman's Compensation will not be adversely affected by hiring a consumer as a provider/ Income Tax Credit is available to Centers hiring.

To help staff/agencies who are having a difficult time accepting consumers as providers:

1. Target special training on Consumers As Provider to those staff.
2. Have agency in-services on the topic.
3. Have open forums in the organization to talk about it.
4. Have consumer-providers mentor/ have staff mentor consumer-providers.

5. Having leaders of CMHC's that support consumers as providers talking to their colleges to support the movement, taking risks to hire consumer-providers.

Training

Summary of Barrier:

Barrier - Consumer-providers' access to extensive, relevant training

Potential Solutions for Training

1. The Office of Mental Health sponsors training provided to all case managers in the system. Training includes an orientation to severe mental illness, treatment indicators, and case management functions. Training also includes periodic continuing education sessions. In-service training and periodic continuing education sessions are also offered to increase case management clinical skills.
2. One agency (out of state) provides extensive training for all staff (including consumer providers), including eleven full days of training during staff's initial 60 days of employment.
3. Denver's case management aid training program consisted of six weeks of formal classroom training, 50 lab hours practicing work skills with each other in the classroom, and 300 hours (14 weeks) of on-the-job training. Classroom instruction included 45 hours of direct skills training (stress management, study skills, cognitive training), 45 hours of interviewing, acquiring benefits, identifying deficits in independent living skills, and transportation logistics, and 30 hours on case management and crisis intervention (Sherman & Porter, 1991).
4. Consumer-providers should be involved in same training as everyone else e.g. KU Strengths and continuing education (target continuing education toward areas of special needs or desires of consumer-providers).
5. For those consumers interested in working in the field to evaluate interest, they may attend the KU strengths training.
6. Centers increase their own ability to train staff (including consumer-providers) on agency policies.
7. Agencies sponsor all-agency training on consumer-providers e.g. Dan Fisher

8. Consumers interested in being providers can attend KUSSW's consumer as provider training.

Supervision

Summary of Barriers:

Barrier 1 - Supervisory staff may not have the knowledge, commitment, and understanding of the issues (accommodations, supports, organizational culture, etc.) for successful integration of consumer-providers into the agency.

Barrier 2 - It can be difficult for supervisors to know how to respond when a consumer-provider becomes ill.

Potential Solutions for Supervision

Supervision that is Sensitive to Consumer-Provider Issues:

1. The supervisor or other leader in the organization educates all staff on benefits, barriers, and needs of consumers as providers. The supervisor presents information in a positive way and sets an enthusiastic tone for hiring consumers as providers.
2. The supervisor has training in issues related to consumers as providers such as ADA and accommodations.
3. A supervisor who does not believe that hiring consumers as providers is a good idea should not be forced to supervise consumer-providers.
4. A supervisor supervising a consumer-provider should have a supervisor who is knowledgeable about and sensitive to consumer-provider issues in order to help resolve difficulties and overcome barriers.
5. Consumer-providers were asked what had been helpful in their supervision. Their answers included:
 - Flexibility (e.g. in scheduling, taking sick leave, having flex time)
 - Having the supervisor asking the consumer-provider what their comfort level is in performing a certain task
 - Having a back up for clients when they need to be gone
 - Positive and critical feedback
 - Having their supervisor be up front about what is going on in the agency that is impacting the situation with staff or clients
 - Clear, precise instructions
 - Celebrating accomplishments

6. The supervisor should have an appreciation of the challenges faced by consumer providers, and be understanding, supportive, and want the consumer provider to succeed.
7. Supervisors may need additional support and technical assistance given that consumer provision of mental health services is a relatively recent phenomenon and as such, supervisors may experience difficulty.
8. Supervision needs to be provided that is directed at helping the consumer provider make decisions about which clients need their time and resources. Supervision discussions should be focussed on the types of interventions used by the consumer providers, whether or not the interventions were working and alternative strategies the consumer provider might try.
9. The supervisor can be helpful in responding to non-consumer providers' attitudes toward consumers working in the agency.

The Supervisor Responding to Issues Around their Employees Illness

1. The agency must establish a standard response to illness. For example:
 - a. Agencies must accept a wider range of acceptable behavior in the workplace due to the diverse nature of employees hired in mental health.
 - b. Many agencies confront the difficulty of discerning when behavior is "symptomatic". "Supervisors must take into account the context in which the behavior is occurring". What may be considered a strange or unusual behavior in one situation may be appropriate in another.
 - c. However, if an agency denies the strange and unusual behavior of a co-worker, such denial can be detrimental to the consumer provider. It is important to recognize that some consumer providers encourage a straightforward approach and thus welcome feedback.
 - d. If a consumer providers' behavior is disruptive to the agency, one option for the supervisor is to request the individual to take a leave of absence. Assurance that the consumer provider is not being fired must be provided. In addition, assistance to the consumer provider can be offered.
 - e. If a consumer provider is asked to take a leave of absence, help the consumer provider prepare for their return by making plans before he or she leaves. This includes discussions surrounding the expected length of the leave, how to respond if more time is needed, and how the leave should be explained to other staff.

2. Upon hiring, discuss and develop a written agreement about how the consumer-provider wants to handle the situation if they need hospitalization. The agreement could include:

- Who to notify
- What to tell clients & staff
- How to handle when the person comes back
- How is the decision to return to work made
- Who gets the information about the agreement – at a minimum, the consumer-provider's supervisor and their supervisor's supervisor and anyone else the consumer-provider would want to know.

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Scenario:

Your large CSS program has posted an advertisement for a case manager. You are in charge of reviewing applications and find one for Jill Jones.

Jill meets all the qualifications and preferences you have advertised for but she has a few unexplained gaps in her work history.

Jill is asked to come in for an interview. In the interview, Jill asks some well thought through questions about the work in CSS and details of the case management position. From her responses and her educational qualifications, you are impressed and want to hire her.

Towards the conclusion of the interview, Jill mentions that she has direct experience as a consumer of psychiatric services. Further she says she continues to gain support and services in the CSS program at your Center. Jill goes on to say how much she wants this job, and how she feels that she can be a great asset to consumers and the organization. Jill mentions that she does not want to give up her services and supports from CSS and hopes she will not have to make a decision between having a job or having supports.

You admire her forthrightness and think she could do a terrific job working directly with consumers.

So what will you do?