

Hiring and Supporting Consumer Staff

(2006)

I once wrote that I thought that the single most transforming thing the mental health system could do would be to hire large numbers of consumer staff. Now, because of the Mental Health Services Act counties all over the state are doing just that. I wrote that because I believe that hiring consumer staff will have an enormous anti-stigma effect challenging the prevailing image of people with mental illnesses as incompetent, irresponsible, and dangerous.

Consumers who are willing to disclose their experiences with mental illnesses hired in any position will have opportunities to reduce stigma in a variety of ways. Broadly speaking stigma reduction can be directed towards 1) the people we serve and their families (for example by being a successful role model), 2) mental health staff and administration (for example by changing staff's perceptions of the abilities of people with mental illnesses by working alongside them as their colleagues or by "vetting" policies and practice guidelines from a consumer perspective), and 3) our community (for example by promoting through self disclosure social networks that welcome people with mental illnesses or promoting more positive media coverage of mental illness by publicly disclosing personal experiences with mental illness).

However, we must be careful as we move forwards. Potential pitfalls seem to be everywhere. It seems to me that the foremost risk is that if our consumer staff work poorly the stereotypes will be reinforced rather than challenged. If we include consumers in our clinics in only limited protected roles and the professional staff have to heavily support them and give them lots of accommodations we risk reinforcing staff's negative expectations. If we create independent consumer run programs that are poorly run, aren't held accountable, have violent incidents, and turn to the local clinic for help in crises we risk reinforcing our communities' fears.

When the Village first began we hired a few of our "best" members to work answering the phones and making lunches for homeless people. They worked three hours a week in stipend jobs making \$65 per month so their SSI checks wouldn't be affected. They mostly did their jobs poorly and we were "understanding." When Paul Barry came to us from Corporate Cookie, a busy cookie store on Wilshire Blvd. run by people with mental illnesses, he said that we weren't going to have any more little stipend jobs. All jobs would be five days a week, two to four hours a day, and furthermore, all work would have to be done at community standards. I said that was the stupidest idea I'd ever heard. Didn't he understand that these people had serious mental illnesses? They're disabled. They couldn't even do the stipend jobs well.

Since the psychiatrist doesn't run the employment program at the Village we did it Paul's way. Sure enough, he ended up firing most of them. But before I could get up to his office to say, "I told you so!" the strangest thing happened. Most of them wanted to try to get their jobs back and I was too busy working with them figuring out what had gone wrong and helping them change it. We changed

medications, created new support plans, even worked on stopping drugs and alcohol, so they could succeed. And Paul fired most of them again.

By the sixth or seventh time, however, they were starting to really get it. The vast majority of people who did stipend jobs poorly could develop enough to do daily jobs at community standards. Paul called it “work hardening.” I called it frustrating. Ultimately, he was right. Our kindly, low expectations weren’t helping them grow and work effectively.

If everybody has to learn that lesson the hard way like I did, we may be in trouble.

We’re not hiring people with mental illness out of pity for their disabilities, or out of compassion for their struggles, but out of respect for the added strengths and skill sets their experiences have given them. We’re hiring them because they can work effectively, often in ways we can’t, and because if they’re successful it’ll break down stigma and transform all of us.

We’ve already run into difficulties in almost every county with human resource departments mostly because of civil service rules prohibiting affirmative action. Even building in a preference for hiring people with mental illnesses into job descriptions has been elusive. Most counties have reacted by either creating special Peer Advocate or Peer Supporter jobs or by contracting out consumer employment entirely. Both of these approaches widen the distance between consumer staff and “normal” staff decreasing the likelihood of lowering boundaries and stigma and risk creating segregated “separate but equal” arrangements. Unless some arrangement is made for consumers to be integrated as full colleagues we’re unlikely to really succeed.

It’s scary for staff to really accept people with mental illnesses as colleagues. And to be fair, it’s scary for some consumers to give up their “protected” consumer jobs to be integrated. We’re hardly on solid ground for heavy advocacy to human resource administrators who often have other more pressing interests than fighting stigma. To advocate from a position of strength, we need to begin with what employment roles consumer staff will add to our services.

The relevant qualification is not a documented diagnosis or open case in treatment, but rather the ability to use past experiences and self disclosure to help people. We need to be specific about how we expect them to use those experiences (and equally importantly, deal with fears about how they shouldn’t be using those experiences). What are the roles consumers can perform that other people can’t?

1) Consumer representative – Consumers should be included in all levels of decision making, planning, and program design embracing the spirit of “nothing about us without us.” Representatives must be careful to present not just their personal positions, or even just those positions sanctioned by the “consumer movement” and their established organizations. They are responsible for presenting the range of positions of the affected consumers carefully including those unable to articulately speak for themselves.

2) Peer advocate – Peer advocates work to help improve the system on behalf of individual consumers. This must be a collaborative arrangement where the peer advocate’s agenda clearly represents the choices of the consumer they are representing, rather than the advocate’s agenda, since they are the ones who will experience the consequences of the advocacy effort, both good and bad, most directly.

3) Peer supporter – Peer supporters rely on listening to people’s stories and sharing their own stories to support individual consumers. Care must be taken to emphasize shared personhood rather than shared patienthood even when sharing experiences directly related to illnesses and their symptoms. An important function of peer supporters is to reduce the possible stigma and personal damage of the diagnostic labeling process by sharing and thereby normalizing people’s experiences. The goal of peer support is not to give advice through the shared stories, but to strengthen the person being supported by creating a feeling of being understood, educating them, broadening their awareness, opening up new opportunities, and increasing their sense of hope, personal power and self-responsibility. Peer supporters will likely benefit from the sharing process as well, but must make sure that meeting the other person’s needs take precedence over meeting their own needs.

4) Peer bridger - Peer bridgers may act as a bridge into mental health services outreaching and engaging with people who are not collaborating voluntarily with mental health services. Peer bridgers may also act as a bridge to community connections for people by helping people begin to move beyond strictly professional support, by using themselves as positive role models of people using community supports, and by opening up new opportunities in our community for people with mental illnesses by sharing their stories within the community.

5) Peer counselor and peer case manager – These people provide the same range of case management and community support services as their non-mentally ill colleagues while emphasizing the strengths of their shared experiences, for example promoting engagement, risk taking, empowerment, self-responsibility, acceptance, independence, and graduation. It is expected that these staff’s effectiveness would benefit from a decreased perception of power differential and less professional distance.

6) Peer self-help facilitator – Consumers may be facilitators of self-help groups and programs, either volunteer or paid. Then they are required to maintain staff responsibilities and ethics. (For example, they may no longer date or have financial dealings with other group members.) Some people’s responsibilities will change within the same group when they are hired or leave employment in that program. It is possible to be a participant in one group or program and a staff in another one.

The bottom line is that none of these roles can be accomplished unless consumers are hired. That’s solid ground to approach administration with. It’s devoid of pity, compassion, or affirmative action.

Each of these roles do not necessarily define job titles or the person’s professional identity. They all may be integrated into our “normal” job descriptions. Each requires specific skill sets beyond experience with mental illness that can be included as “additional qualifications.”

Our next challenge is to properly prepare and support consumer staff so they’ll actually succeed. There’s two basic parts of this task: Job training and personal support. There’s also a need to have training and support available throughout the entire process from recruitment to leadership promotion. Here’s a table of what’s needed:

Function	Content
Engagement	Identifying consumers and families in clinics – engaging with clients interested in MH employment Consumer advisory boards Volunteer assignments and mentoring at their clinic Inclusion in Wellness activities / Self-help programs Inclusion in clinic planning, education, and operations
Job Training	Build on existing curriculums Add needed skills <ul style="list-style-type: none"> • Case management • Recovery relationships • Clinic / program operations • Billing • Self help groups Specific content for each role Specific content for each clinic / program
Transitional Support/Role Training	Consumer issues <ul style="list-style-type: none"> • Disclosure • Peer roles • Consumer movement and advocacy • Personal role changes • Benefits effects • Moving clinical care Includes Support Group

Hiring	<p>Job descriptions</p> <p>Job qualifications</p> <p>Approving job candidates</p> <p>Local interviewing and hiring</p>
Orientation	<p>Systematized orientation for all staff</p> <p>Assign onsite clinic supervisor and peer mentor</p> <p>Shadowing variety of staff to be exposed to all clinic functions</p>
On Job Supervision	<p>Job expectations and performance evaluations</p> <p>Extra onsite training if needed</p> <p>Mentoring for supervisors (supervisor group to share problem solving)</p>
On Job Support	<p>Consumer Issues focus</p> <ul style="list-style-type: none"> • Boundary issues • Confidence • Fear of losing benefits • Acceptance <p>Peer Mentors onsite</p> <p>Ongoing Support Group</p> <p>Accommodations</p> <ul style="list-style-type: none"> • Utilizing a job coach • Providing additional individualized training. • Designating a co-worker as peer support. • Benefits counseling • Flexible Scheduling • Job sharing • Allowing workers to shift hours for appointments • Leave during a crisis / hospitalization <p>Train team staff to be able to include and support consumer staff</p>

	<ul style="list-style-type: none"> • Confidentiality • Role confusion • Inclusion • Supervision
<p>Transition to integrated employment (non-consumer restricted jobs)</p>	<p>Additional training and HR policies to transition to paraprofessional jobs</p> <ul style="list-style-type: none"> • Administrative Assistant • Job Coach • Housing developer • Community support worker • Program Manager • Case Manager • Case Manager Assistant <p>Supervision to full staff responsibility</p> <p>Support for professional training to transition to professional jobs</p> <p>Career ladders</p> <p>Leadership training and mentoring</p>

I don't think we'll have much disagreement over the items in this list. (Although there may be substantial arguments over who has the expertise and authority to provide these trainings and supports. In particular, which of them "must" be provided by consumers can be a thorny issue.) I expect the problem will be having the will to actually create all those items. It's easy to look at a table like that and say, "All that would be nice, but we don't have the resources, and it would take too much time to set up, and we don't have anything like that for our 'normal' staff, and we need to get started now...so let's just hire a few consumer staff now and see how it goes."

The further we go along with hiring and supporting consumers, as with most of this transformation effort, the more detailed and complex everything gets, but also the more plausible it seems.

One final counterpoint before I close: What about family members? Both the President's Commission Report and the MHSa routinely lump "consumers and their families" together and yet their fates seem to be playing out very differently. Families have been effectively involved in the planning process, but rarely included in direct service delivery or mental health employment. We see large numbers of consumers almost everywhere wanting jobs in mental health to "give back," but very few family members. There's probably a wide array of reasons for this, but at least for now families aren't being employed and it isn't high on anyone's advocacy agenda to do anything about it. Should it be?

As we've begun using consumer volunteers and staff in the county clinics in Los Angeles, the reactions have been dramatic. Some staff are so outraged they walk out of the room whenever a consumer volunteer is there. Even if we solve the myriad of administrative issues we're still going to be faced with staff's serious concerns about blurring boundaries, engaging openly in "dual roles," preserving ethics, confidentiality, emotional and physical safety, therapeutic effectiveness, and, perhaps most importantly, their personal and professional comfort.

Here's a few of my thoughts as this process unfolds:

1) The first consumer volunteers / staff are "Jackie Robinsons." They need to know before they take the position that this puts extra burdens and responsibilities on them that their followers may not face and agree to that as part of the assignment. Supportive staff is the equivalent of the Dodger's management. Unsupportive staff should become increasingly uncomfortable about the underside of their accepted segregating practices.

2) Though many consumers have had significant success in education or employment before volunteering or working in their own clinic, this assignment was far more satisfying for them. It seems that it's much more healing to be accepted alongside someone who does know how ill you've been and can become than by someone who doesn't know first hand the illness you're hiding inside. Though it's tempting to keep the ethics clearer by hiring and volunteering only outside the treating clinic, to do so would deprive people of an important piece of healing and recovery.

3) The changes that occur between therapist and client as they work alongside each other in the clinic parallel the changes that are supposed to occur during the "termination phase" of therapy. Most of us don't do termination much or well because it's so uncomfortable. Nonetheless, it gives us a framework for a "therapeutic" usage of the role and boundary changes that occur as consumers are volunteering and working alongside us. Correspondingly, volunteering and working alongside us can become another useful tool for ending long term therapy.

4) Some staff are confident of their ability to help people within the comfortable role of therapist, but insecure of their abilities once that role is no longer rigidly maintained. Stretching their abilities will make it more likely we'll be able to help the multitudes that are "inappropriate for therapy." We'll need to help each other increase our ethical skills to move safely beyond our protected comfort zone safely. This approach requires more individual attention to ethics and safety, not less.

In one clinic, I was asked by a reluctant staff what the goals of hiring our own consumers were. I responded that I thought that the ultimate goals were to create an environment where people with mental illnesses could be our colleagues in everywhere and an environment where those people with mental illnesses already working among us would feel safe enough to disclose their illnesses. He replied that he didn't think people with mental illnesses should be our colleagues. He didn't think people with mental illnesses should be social workers or psychologists. He thought that ill people deserved to be treated by a mental health professional who wasn't damaged, who was healthy themselves. We have a long way to go to break down our own internal barriers that keep "them" from recovering.