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CONNECTICUT WORKFORCE COLLABORATIVE ON BEHAVIORAL HEALTH

Increasing Employment of Persons in Recovery In the Mental Health Workforce: Emerging Practices

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Embrace HOPE Expect Change
Connecticut's Mental Health System is Transforming

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Introduction and background

Significantly increasing the employment of consumers[1] in the mental health workforce has been identified as an important objective in numerous key reports (U.S. Department of Health and Human Services, 1999; U.S. Department of Health and Human Services, 2003; Hoge, Morris, Daniels, et al 2007); State of Connecticut Department of Mental Health and Addiction Services, 2007). These reports have also noted that there are multiple pathways to employment. Persons in recovery may also have differing preferences regarding disclosure in employment settings.

While there is scant literature or research on best practices to promote employment of persons in recovery in the mental health workforce, there is a considerable amount of information available on what can be described as e*merging* practices. These are defined by Hyde, Morris, Falls, & Schoenwald (2003) as "very specific approaches to problems or ways of working with particular people that receive high marks from consumers and/or clinicians, but which are too new or used by too few practitioners to have received general, much less scientific attention.[2]

Connecticut's effort to transform its mental health workforce, funded through a federal Transformation State Incentive Grant, includes establishing the Connecticut Recovery Employment Consultation Service (C-RECS), led by persons in recovery**, to promote recruitment, training and retention of persons in recovery from diverse cultural backgrounds in the mental health workforce and enhance the capacity of organizations to engage and support them**. C-RECS will "manage a recruitment and placement service that includes an on-line job bank, and will provide training and support to persons in recovery to facilitate and sustain their role in the workforce. C-RECS will also provide consultation and technical assistance to mental health provider agencies to increase overall organizational receptivity and capacity to integrate persons in recovery into their workforce"

[1] In this paper, the terms "consumer," "person in recovery" and "service user" refer to individuals with serious mental illnesses. The term "in recovery" has historically been used to refer to individuals recovering from substance use disorders and, in recent years, has been used to refer also to persons with psychiatric diagnoses who are in a process of learning to live with the illness and to lead a personally satisfying life. The terms consumer-provider and peer are used in this document to refer to individuals with mental illness working in the field. The term "prosumer" also refers to a consumer working in a paid provider role (Manos, 1993), although it is not widely used at present.

[2] "*Promising"* practices are defined as "interventions that are well known and have expert consensus or other support, but which haven't been as rigorously evaluated scientifically" (pp. 4-5). *Best* practices are …"the closest fit between what we know, based on science, and what we can actually do in the present circumstance" (p.4) (Hyde et al, 2003).

(Workforce Transformation Workgroup, 2007, p.8). C-RECS will function as an operational entity accountable to the Council on Persons in Recovery within the Connecticut Behavioral Health Workforce Collaborative.

Purpose of paper

To guide the implementation and operation of the C-RECS, this paper will identify and define emerging practices to increase employment of adult consumers in the mental health workforce.

Topic areas include

- Consumer preparation for mental health workforce employment
- Recruitment of persons in recovery into the mental health workforce
- Post-hire employment training and support for persons in recovery and for other staff
- Retention of persons in recovery in the mental health workforce
- Organizational change to sustain consumer employment
- Sustaining funding for employment of persons in recovery

In each topic area, emerging practice components are described, including key sources of information. Some of the categories may overlap in practice. For example, continuing employment practices impact on retention, and organizational culture change tasks and actions need to be identified and addressed at each phase. For purposes of understanding and emphasis, however, these are presented as discrete categories. This paper is intended to provide a guide to those actively engaged in increasing employment of persons in recovery in the mental health workforce.

Consumer preparation for mental health workforce employment

Preparation for employment includes the development of competencies – skills, attitudes and behaviors – that enable potential employees to be attractive candidates, both because of their consumer status and/or because of specific competencies they possess, including knowledge of the "lived experience" of mental illness. Relevant practices that serve to prepare consumers include:

- Supported education
- Supported employment
- Pre-service education and training

Supported education

Supported education enables individuals with psychiatric disorders to begin or resume higher education as a pathway to employment, as well as increased self-esteem (Unger, 1990). It has been

used to prepare consumer providers for employment in the mental health field (Ratzlaff, McDiarmid, Marty and Rapp, 2006). The three most common models are specialized programs at educational sites such as a college or university, on-site support services at colleges or universities, and/or community agency-employed mobile staff who offer services to students at multiple educational sites (Mowbray, Brown, Furlong-Norman, & Soydan, 2002; Unger, 1992). In Connecticut, a small number of supported education programs are available in all three modalities at a variety of sites, including clubhouses.[3] The DMHAS Supported Education Task Force has been collecting information and working to enhance partnerships especially between supported education programs and community colleges.

Supported employment

Supported employment is an evidence-based intervention in wide use for many years for which fidelity has been demonstrated (Drake, Merrens & Lynde, 2005). It is "an individualized approach to helping consumers get and keep competitive jobs that fit each individual's goals, preferences, strengths, and abilities" (pp. 376-77). It includes integrated vocational and mental health services; eligibility based on consumer choice; competitive employment as the goal; a job-search process beginning soon after program entry; job choice following consumer preference; support provided over time based on consumer need; and the provision of benefits counseling. Numerous supported employment programs are available in Connecticut, including a peer mentoring program at Kennedy Services in the Southwest Region. While there is little literature explicitly focused on using supported employment to prepare consumers for mental health workforce employment, partnerships with supported employment programs can aid in consumers obtaining mental health workforce employment and in available job support following hire. Consumers in supported employment positions might also move to positions within the mental health system with less support.

Pre-service education and training

Both credit and non-credit bearing education and training programs are available at various locations across the country. Some are aimed specifically at people in recovery who seek to enter the mental

[3] Laurel House in Stamford and the Kennedy Center in Bridgeport were the first supported education programs funded in Connecticut (Dougherty, Hastie, Bernard, Broadhurst, & Marcus, 1992; Wolf & DiPietro, 1992); Bridge House in Bridgeport and other rehabilitation programs offer supported education services, although not all are formally funded for this purpose.

health workforce, and others include or welcome persons in recovery in their program.[4] Whether credit or non-credit-bearing, training programs can be helpful to potential consumer employees by providing educational credentials and the competencies necessary to perform work roles (Linhorst, 2006; Mowbray, 1997; Zipple et al, 1997).

In Connecticut, the MERGE Mental Health Certificate program at Housatonic Community College in Bridgeport (http://www.mergementalhealth.org) has a record of success in graduating consumers who have subsequently been employed in over 20 mental health agencies (Wolf, 2003). The curriculum is also available at Norwalk Community College and Capital Community College. META Services/Recovery Innovations peer employment training (http://metaservices.com/peer_support_training.htm) is now available at HCC in Bridgeport for credit and as part of the MERGE program.

Many Connecticut community colleges also offer human services associate and/or mental health related certificate or program options that may be avenues for persons in recovery to prepare to enter the workforce (Coddington, 2007). The career ladder can lead to subsequent options, such as undergraduate majors in nursing, psychology and social work, followed by graduate level masters and doctoral options in psychology, nursing, social work, and medicine/psychiatry. Formal partnerships between behavioral health and educational systems are essential to assure availability of well-trained staff (Hoge, Morris, Daniels et al 2007, p.17).

Many non-credit-bearing programs are aimed at training persons in recovery for mental health workforce peer specialist positions.[5] In Connecticut, Focus on Recovery-United (ForU) regularly

[4] Among the credit-bearing programs are the Southern New Hampshire University (SNHU) Certificate in Mental Health and Master Degree in Community Mental Health (http://www.snhu.edu/50.asp), the Psychiatric Rehabilitation programs at the School of Health Related Professions of the University of Medicine and Dentistry of New Jersey (from certificate through PhD level; http://shrp.umdnj.edu/smi/academic_program/bachelor_science.htm); Boston University Center for Psychiatric Rehabilitation programs and degrees (http://www.bu.edu/cpr/training/academic.html); the University of Kansas School of Social Welfare (http://www.socwel.ku.edu/Research; Recovery Innovations, formerly META Services, (http://metaservices.com/history.htm) in collaboration with South Mountain Community College (http://www.southmountaincc.edu), and the Psychiatric Rehabilitation Certificate offered at Illinois community colleges (for example, http://www.morainevalley.edu/programs/general/1445.htm). The United States Psychiatric Rehabilitation Association (USPRA) offers a Certified Psychiatric Rehabilitation Practitioner credential that does not require a college degree (http://www.uspra.org/i4a/pages/index.cfm?pageid=3925). The USPRA website also offers a list of psychiatric rehabilitation education programs throughout the country. http://www.uspra.org/i4a/pages/index.cfm?pageid=3954.

[5] Examples include the Georgia Certified Peer Specialist curriculum (http://www.gacps.org/Home.html), META Services/Recovery Innovations peer employment training (http://metaservices.com/peer_support_training.htm) (now

offers WRAP and recovery training (http://www.focusonrecovery.org/); NAMI-CT also offers Peer to Peer, In Our Own Voice, and Consumer Recovery Connections training.[6]
META Services/Recovery Innovations peer employment training (http://metaservices.com/peer_support_training.htm) is now available periodically at Southwest CT Mental Health System (SWCMHS) and HCC in Bridgeport for credit and as part of the MERGE program.

In September 2007, the Connecticut Certification Board (CCB), Focus on Recovery – United (For-U), Connecticut Community for Addiction Recovery (CCAR), and the Yale Program on Recovery and Community Health (PRCH) announced creation of the Connecticut Recovery Supports Collaborative with the intention of creating a curriculum and certification process for Recovery Support Specialist positions (http://www.ctrsc.org).

Whether credit-bearing or non-credit bearing, education and training programs preparing persons in recovery for mental health workforce employment should include curriculum content areas that will enhance competency-building and attractiveness for employment.
Curricula are available to prepare consumers for peer positions (Townsend and Griffin, 2006; Ashcraft, Zeeb & Martin, 2007) and to prepare consumers for general mental health workforce employment (Wolf, Coba & Cirella, 2001), although emphasis currently seems focused on curricula for peer positions that can be Medicaid reimbursable (Georgia Certified Peer Specialist, Connecticut Recovery Supports Collaborative). Some common curriculum topics include: recovery, peer support, self-esteem, community and culture, preparing for work, employment as a path to recovery, communication

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available at SWCMHS and HCC in Bridgeport for credit and as part of the MERGE program), and Howie the Harp Peer Specialist training in New York City (http://www.communityaccess.org/programs/hth.html). Many other organizations and entities offer training related to peer roles, including: NYAPRS (New York Association of Psychiatric Rehabilitation Services; http://www.nyaprs.org) – peer bridger project training consumer-survivors to work with peers discharged from state hospitals; Mental Health Empowerment Project (Albany, NY; http://www.mhepinc.org) – training and technical assistance in mutual self-help and recovery education; DBSA (Depression and Bipolar Support Alliance, Chicago; http://www.DBSAlliance.org) CONTAC (West Virginia; http://www.contac.org) , a national technical assistance center on peer self-help offering training and technical assistance on peer support, peer recovery training, leadership development; consumer as provider training at the University of Kansas School of Social Welfare, Office of Mental Health Research and Training, including internships and support for peer recovery educators in WRAP and Recovery groups (http://www.socwel.ku.edu/Research); the Arizona Recovery Support Specialist Training Institute (Stoneking and McGuffin, 2007). The state of California is in the process of establishing and expanding consumer entry level employment preparation programs to increase workforce participation (California Department of Mental Health, 2007).

[6] See for example http://www.nami.org/MSTemplate.cfm?Section=For_Consumers&Site=NAMI_of_Connecticut,_Inc&Template=/ContentManagement/ContentDisplay.cfm&ContentID=49439); http://www.nami.org/MSTemplate.cfm?Section=Programs131&Site=NAMI_of_Connecticut,_Inc&Template=/ContentManagement/ContentDisplay.cfm&ContentID=51277.)

skills, conflict resolution, understanding trauma, co-occurring disorders, challenging situations, partnering with professionals (Ashcraft, Zeeb & Martin, 2007).

Some additional key recommended curriculum areas include treatment planning and documentation (Migdole, 2007), cultural competence[7], knowledge of the Americans with Disability Act (ADA)[8], and advocacy training,[9]. The Americans with Disabilities Act is especially relevant to employment issues including disclosure and accommodations (Boston University Center for Psychiatric Rehabilitation, 1997, 2002; Ralph, 2002; Riffer, 2000; Schneider, 1998). ADA knowledge is relevant at pre-hire as well as during newly-hired and continuing employment phases.

Services should be responsive to the culture and ethnicity of those who use them. Staff, including both persons in recovery and others, should also be knowledgeable about and sensitive to diverse cultures, including the cultures of people living with mental illnesses

Recruitment of persons in recovery into the mental health workforce

Recruitment is the process by which potential employees are selected and hired. Recruitment of persons in recovery may require expanding and reexamining usual recruitment practices. In this section, key areas of recruitment are identified.

[7] Cultural competence can be viewed as "a set of problem-solving skills" (Whaley & Davis, 2007, p. 565), including recognition and understanding of the dynamic interplay between cultural heritage and adaptation, and integrating this knowledge into care-giving. Whaley and Davis view experiential training and formal culture training as important pathways to cultural competence. Training should be aimed to enable all staff to be knowledgeable about and sensitive to diverse cultures, including the cultures of people living with mental illnesses (Hansen, 2004).

[8] Some key national organizations include the National Coalition of Mental Health Consumer/Survivor Organizations (see above); NARPA – National Association of Rights Protection and Advocacy (http://www.narpa.org), Bazelon Center for Mental Health Law (http://www.bazelon.org).

[9] The newly created National Coalition of Mental Health Consumer/Survivor Organizations (NCMHCSO) (http://www.ncmhso.org) consists of organizations run by consumers representing 28 states and the District of Columbia, with a mission of ensuring that consumer rights policies continue to move towards promoting full participation and integration in the community. In Connecticut, Advocacy Unlimited (http://www.mindlink.org) and Focus on Recovery-United (http://www.focusonrecovery.org) are two active advocacy organizations. NAMI-CT also includes an advocacy component and offers consumer support groups. The Connecticut Legal Rights Project (http://www.mindlink.org/clrp.html) focuses on the rights of persons with mental illnesses. These organizations may offer curriculum development resources and assistance.

Use an affirmative action approach; set hiring goals

Employment of consumers in the mental health workforce has been promoted at least since the 1990's (Mowbray, Moxley, Jasper & Howell, 1997). However, only relatively recently with the President's New Freedom Report (2003) has employment of persons in recovery been identified as a key system change goal. Consequently, an affirmative action approach including setting hiring goals may be very helpful in making sure that agencies act to employ consumers at all levels (Carling, 1995; Zipple et al, 1997; Hansen, 2004; Mental Health Commission, 2005). Marrone (2007) suggests using a contractual requirement with funded mental health service organizations that compels them to recruit and promote people with mental illness affirmatively at all levels.

Address cultural competence

Townsend & Griffin (2006) note the importance of recruiting consumers from diverse ethnic, racial, cultural and disability groups. They suggest that staff from diverse backgrounds can develop services that adapt self-help concepts from racial and ethnic culture; utilize natural community supports, relationships and resources; increase awareness of racial, ethnic and cultural factors influencing individual clients' recovery; and encourage consumers and families from diverse groups to build relationships with diverse staff (p. 14; Lopez, Kopelowicz & Canive, 2002). Townsend and Griffin (2006) suggest that agencies may give preference to applicants who meet the minimum required skills and also have additional skills, such as cultural competence, bilingual ability, and/or experience with mental illness.

Create well-defined position descriptions

Good human resource practice suggests that well-defined position descriptions are essential in finding qualified candidates for available positions. The absence of role clarity is a significant contributor to staff turnover in the mental health workforce (Hoge, Morris, Daniels et al, 2007); Townsend & Griffin (2006) note that job descriptions should include essential functions, needed skills or competencies, and minimum requirements together with key responsibilities (p.12). For positions explicitly for consumers, lived experience with mental illness would be one minimum requirement. These authors provide sample job descriptions to assist employers. Gates & Akabas (2007) emphasize the importance of well-defined job tasks; Hansen (2004) stressed the importance of job descriptions that clearly describe daily tasks, roles and responsibilities. Research with direct care staff in the developmental disabilities field has shown that employees who were provided with "realistic job

previews" of duties prior to hiring were likely to remain in their positions longer (Hewitt & Larson, 2007).

Recruit for a variety of positions

Because of stigma, recruiting self-disclosed people in recovery may be difficult (Linhorst, 2006). Mowbray et al (1996) have cautioned against creating positions explicitly designed for consumers: "Hiring consumers into specially identified positions, such as PSS [peer support specialists] may be inherently problematic. It could be argued that creating a programmatic culture in which there are dual tracks for professionals and consumer workers will only foment divisiveness, raising equity and justice issues" (p. 64). However, the recent burgeoning of peer training and employment may also suggest that a critical mass of consumer workers can lead to system transformation (Anthony & Ashcraft, 2005; Ashcraft & Anthony, 2005). Efforts are needed to reduce barriers to hiring people with mental illnesses in all positions and at all levels, whether or not they disclose their illness.[10] Agencies need to consider whether they wish to In recruiting for consumer-identified positions, agencies may need to reframe their mission statement, change their operating style, and shift their organizational in order to hire people in recovery throughout the organization. These strategies may evolve over time.

Advertise widely and creatively

Several authors have recommended numerous advertising strategies, including newspapers and job services, mutual support groups, consumer-run programs, club-houses, advocacy groups, vocational service providers, family groups, mental health provider professional organizations, "shoulder-tapping/personal contacts" (Hansen, p.14), nomination, and word of mouth (Hansen, 2004; Linhorst , 2006, Zipple et al, 1997; Townsend & Griffin, 2006). They also suggest announcing positions at formal and informal meetings; offering training and recruiting applicants from among participants; sending personal invitations; distributing postings to websites, message boards, public access TV and radio; advertising locally, statewide and nationally to consumer, disability, ethnic and culturally diverse individuals, groups and organizations (p.15); and sharing position announcements with other

[10] According to NAMI (2007), 1 in 17 Americans has a serious mental illness, and 1 in 5 families is affected by mental illness. Statistically, a significant number of currently employed staff are individuals with serious mental illnesses, though they may not have disclosed their condition. A concomitant goal to increasing the employment of persons in recovery should be creating an environment in which the choice to disclose about mental illness can be acceptable and non-threatening. Creating a "positive culture of healing" (Fisher, 1993) throughout mental health services could result in workforce participants becoming more open about their experiences with emotional disorders, and would enhance service and system transformation. See also Ralph (2002) and Schneider (1998).

service systems and government sponsored groups and professional organizations. They recommend maintaining a continuous open recruitment list for available positions. Linhorst (2006) builds on the suggestion by Zipple et al (1997) that agencies identify an employment liaison to maintain contacts on an ongoing basis.[11]

Conduct well-structured interviews

In general, the same interview style and questions should be used for all candidates. Interviewers need to be familiar with the Americans with Disabilities Act (ADA) (Townsend & Griffin, 2006) in terms of what providers can and cannot consider during the employment process, and what reasonable accommodations are required. Linhorst (2006) and Carling (1995) note the benefits of having consumer-providers currently employed at the agency serve on interviewing committees, and possibly offering information about their work experiences. This can help interviewees be at greater ease and provide direct evidence of the agency's commitment to consumer involvement (Hansen, 2004). Koerner and Max (2007) offer explicit information about permissible and impermissible interview questions.

Orient staff to consumer employment

Current staff should be part of the decision-making process to employ more persons in recovery in the agency; and it is important that they be aware and become supportive of efforts to employ consumers as part of the agency workforce. Gates and Akabas (2007) note, "Role confusion and conflict appeared to occur when agencies did not prepare non-peer staff for the inclusion of a peer colleague. They were not provided with training on issues around working with someone with a mental health condition or the expectations for the peer at the agency" (p. 298-99). The authors recommend orientation and training for all constituencies, including peers, non-peers, and consumers, including clarity around roles and the ADA (p. 302). Other sources affirm this recommendation (Mowbray et al, 1997; Hansen, 2004, Chinman et al, 2006, Townsend & Griffin, 2006). [12]

[11] In Connecticut, collaboration is suggested with the Bureau of Rehabilitation Services and Department of Social Services' Connect-ability website (http://www.connect-ability.com) and the Connecticut Network of Care for Behavioral Health (http://connecticut.networkofcare.org/mh/home/index.cfm).

[12] Education of current non-consumer staff about the perspectives of persons in recovery is a curriculum area relevant across all categories described in this paper. The NAMI provider-to-provider curriculum is one example. (http://www.nami.org/template.cfm?section=Provider_Education). Some attention is given this topic in recent literature (Chinman, Young, Hassell, & Davidson, 2006; Townsend & Griffin, 2006; Gates & Akabas, 2007). More specific attention to orienting non-consumer staff to including and partnering with persons in recovery in the mental health workforce is recommended, with consumers as presenters and faculty.

Numerous reports have stressed the value and importance of consumers/persons in recovery and family members serving as faculty for all mental health workforce training (State of Connecticut, 2007; Hoge, Morris, Daniels & et al, 2007; Anthony & Ashcraft, 2005; Simpson & House, 2002).

Assure adequate compensation

The literature on consumer-provider employment suggests that historically, consumer employees have been paid at lower rates than non-consumer employees. It is essential that equitable pay scales be implemented to encourage recruitment of qualified employees and to avoid creating a "two-class system" (Hansen, 2004; Gates & Akabas, 2007, Mowbray et al, 1997). Salary and benefits are clear determinants of turnover rates among the mental health workforce (Hoge, Morris, Daniels et al, 2007).

Address impact on entitlements

Agency human resource staff need to develop expertise on benefits requirements so that they can help consumer employees determine the number of hours they can work in relation to pre-existing benefits (Gates & Akabas, 2007; Hansen, 2004); persons in recovery also need to become as informed as possible about their individual circumstances and how to manage paid employment relative to benefits and entitlements.

Post-hire employment training and support for persons in recovery and for other staff

After persons in recovery are hired, numerous important steps can help make their employment experience a positive one and support integration of all staff. Some key aspects are described below.

Provide effective training and orientation

The literature is clear that effective training and orientation are essential for consumer-providers (Townsend & Griffin, 2006; Hansen, 2004; Linhorst, 2006; Gates & Akabas, 2007). Some elements of training include general new employee orientation (agency mission and vision, hours of operation, personnel policies, health care benefits), specific job requirements and expectations, strategies for working with agency staff, self-care, personal recovery planning, confidentiality, dual roles, boundaries, ethnics, and disclosure (Townsend & Griffin, 2006; Silver, 2004).

Ongoing interactive training about employment and integration of persons in recovery into the agency workforce should involve all staff with consumer staff serving as faculty.

Assure adequate supervision

Effective supervision is critical for successful employment of persons in recovery. (Linhorst, 2006; Hansen, 2004; Townsend & Griffin, 2006; Gates & Akabas, 2007; Koerner & Max, 2007). Issues such as job and role clarification, expectations, and performance; stigma; confidentiality; disclosure; dual roles; and working as a team member can all be addressed most easily in supervision (Townsend & Griffin, 2006; Gates & Akabas, 2007). Supervisors thus must be oriented to and trained regarding issues raised by employment of persons in recovery; and they must also be able effectively to supervise non-consumer staff regarding issues they experience in relation to consumer employment (boundaries, dual roles, etc.).

Offer support for consumer-providers

Support can be provided in multiple ways including agency policies that demonstrate commitment to employment and integration of persons in recovery, as well as the formal and informal actions of leaders and staff, such as making sure to include peer and consumer-provider staff in all teams, and offering opportunities for employed consumers to express concerns or easily redress grievances (Linhorst, 2006; Hansen, 2004; Townsend & Griffin, 2006). Gates & Akabas (2007) emphasize the benefits of social support. Another potential strategy is creation of a union or organization for service users employed in the mental health workforce (Hansen, 2004 p.29).

Implement and maintain effective human resources practices

As Koerner and Max (2007) emphasize, good human resources practices benefit all employees and should be the norm. These include consistent performance standards, clarity about essential elements of each job, knowledge and practice regarding accommodations and the ADA, policies prohibiting dual relationships between employees as well as between employees and clients.
Gates and Akabas (2007) and Townsend and Griffin (2006) also stress the importance of clear policies on confidentiality. Organizations may need to review and strengthen their human resource policies and practices in general, and ensure that they are applied consistently and fairly to employees who are persons in recovery. Failure to apply such policies and procedures to consumer employees can undermine just as easily as applying policies and procedures in a discriminatory manner.

Make reasonable accommodations available

Reasonable accommodations are an important part of good human resources practice, and also merit specific consideration. Koerner and Max (2007) offer examples of what reasonable accommodations are and are not, as well as what classes are protected (for example, recovering addicts are a protected class; active addicts are not). They note that offering accommodations can be very beneficial to agencies in retention of well-performing employees, and argue that it can cost up to a year's salary to replace an employee. Flexibility and reasonable accommodations can improve the workplace and enhance staff motivation. (Hansen, 2004; Townsend & Griffin, 2006).

Retention of persons in recovery in the mental health workforce

Retention is presented here as a category separate from ongoing employment, though they are certainly related. It is important to consider actions and strategies that will encourage employees who are persons in recovery to remain in the field, either at the agency of hire and/or in another agency in a related role. Some emerging practices that can positively impact retention are described below.

Offer professional and career development opportunities

Training and learning opportunities should be ongoing for all staff, including staff who are persons in recovery (Linhorst, 2006). Through employees' supervision and on-the-job experience, areas for new learning and growth should be identified. Education and training opportunities can enhance staff performance. Training stipends, tuition assistance, and loan forgiveness are recommended (Hoge, Morris, Daniels et al 2007).

Identify and encourage promotion opportunities

Promotion opportunities and actual promotions are important affirmative employment experiences (Marrone, 2007; Linhorst, 2006; Mental Health Commission, 2005). As noted earlier, it is essential not to create a two-track system for employment that prevents advancement of persons in recovery. It is important to identify career path choices that can be realized by consumer employees and to educate them about these options. Agencies that are proactive in promotion will be perceived more positively by current and potential employees, thereby promoting recruitment and retention.

Assure ongoing feedback and communication about roles and boundaries

According to Townsend and Griffin, "Boundaries include the formal and informal understanding of how people interact with others. In the mental health setting, boundaries commonly exist between staff and service recipients, between staff members and their colleagues, among agency consumers and their peers and between consumers and their family members." (p. 24). They stress the importance of open discussion and guidance regarding boundaries as well as agency code of ethics Ongoing communication in these areas can avoid confusion and costly mistakes while reassuring staff that when issues arise, they will be addressed (Townsend & Griffin, 2006; Gates & Akabas, 2007).

Offer adequate benefits for all employees (including sick leave)

Provisions for sick leave are included in general employee benefits, and may be particularly important for some staff, including persons in recovery, at some points in time (Hansen, 2004). Koerner and Max (2007) note that flexibility in sick leave availability may help in retaining consumer employees, which can be a win-win situation for all parties.

Continue to reduce stigma and discrimination

An agency environment that promotes accepting attitudes and behaviors about people with mental illnesses can impact retention (Hansen, 2004; Linhorst, 2006; Marrone, 2007, Corrigan, Mueser, Bond et al, 2007). The perception of a friendly, supportive, welcoming environment can help all employees, including consumer-providers, feel valued and competent. Relevant practices include regular discussions and get-togethers for all staff and consumer-provider staff serving as faculty for ongoing stigma-reduction training (Corrigan and Gelb, 2006).

Promote and create a supportive organizational culture

A supportive organizational culture benefits all employees, including self-disclosed persons in recovery. Promoting recovery in agency practice, accepting and valuing differences, considering persons in recovery valued and essential team-members, and encouraging constructive conflict resolution, sets a strong agency foundation for positive staff attitudes and empowering services in partnership with clients (Linhorst, 2006; Marrone, 2007; Gates & Akabas, 2007; Davidson, Chinman, Sells & Rowe, 2006; Chinman, Young, Hassell & Davidson, 2006).

Organizational change to sustain consumer employment and transform service delivery

Most providers serving individuals with serious mental illnesses are challenged to change long-standing attitudes and assumptions in order to support their clients' recovery. Employment of persons in recovery as part of the workforce is a potentially transformative step towards long-lasting organizational change. Some emerging practices related to organizational change are described below.

Use stages of organizational change as a guide for undertaking successful organizational change

Organizational change models can be useful in guiding organizational change by considering stages of change, needed actions and those who should be involved at each stage (Chinman, Young, Hassell & Davidson, 2006).[13] The Simpson Transfer Model (2002) consists of the action stages of exposure, adoption, implementation and practice. Simpson and Chinman et al emphasize staff motivations and institutional resources as crucial in moving from exposure to implementation. Chinman et al (2006) emphasize the importance of support from top management and some level of buy-in from all organizational levels. They suggest that during this stage, culture change begins that helps all staff to recognize both the concept of recovery as well as the benefits of employing staff who are persons in recovery. During adoption, in addition to employing consumers, an agency should create an implementation team to promote a supportive organizational culture, as well as to deal with barriers to the recruitment and retention of these employees. Adequate resources and support are essential. During practice (ongoing employment of consumer-providers), they suggest demonstrating feasibility and utility of the change initiatives. Incentives can also be helpful in supporting this kind of change. Awareness of the "tipping point" (Gladwell, 2002) in the change process can also be beneficial.

Develop continuous feedback mechanisms for all stakeholders to increase staff satisfaction, encourage a positive work environment, and promote client empowerment and satisfaction

Employees who are valued within the agency will be more able to value their clients. Lessons from a project designed to increase work and recovery-oriented programming and practices suggested that staff whose concerns about space, work-load, and work environment were addressed were able to become more receptive to supporting their clients' empowerment (New York Work Exchange, 2004).

[13] Prochaska & Levesque (2001) identify five stages of change: precontemplation, contemplation, preparation, action, and maintenance. According to Hyde, Falls, Morris & Shoenwald (2003), these are sometimes shortened to contemplation/consensus-building; enactment/implementation; and maintenance/sustaining. These authors also cite stages identified by NASMHPD as unaware/uninterested, motivating, implementing, sustaining, and improving (p. 34).

Additional research is needed regarding the relationships among on-going feedback, staff, and client satisfaction.

Involve consumers at all levels of organizational decision-making

As is the case with all efforts to integrate a previously disenfranchised group, involvement and participation of service users at all organizational decision-making levels is necessary to bring about substantive change (Hansen, 2004, Barrett, Pratt, Basto & Gill, 2000; Linhorst, 2006). Thus, agencies should work towards employing persons in recovery in a variety of roles and positions, and should include persons in recovery in their decision-making and governing structures.[14]

Implement policy changes to transform organizational structure and function

As employment of persons in recovery increases, a variety of policies will need reconsideration and revision. Ashcraft and Anthony (2005) and Anthony and Ashcraft (2005) offer some suggest that easily-understandable policies be values-based rather than primarily rules-based, that they be flexible, person-centered, supportive of personal recovery, and professionally and organizationally supportive (Ashcraft & Anthony, 2005, p. 16). The META Services Policy and Procedure Manual intentionally consists of a compilation of letters to employees showing how behavior, attitudes and agency environment can reinforce values and mission (see also http://www.metaservices.com/history.htm).

Build in on-going evaluation to determine effectiveness and impact on service delivery

It is essential that projects aimed to increase employment of persons in recovery in the mental health workforce be evaluated. While evidence exists that employment of persons in recovery can produce positive outcomes for service users in some settings (Corrigan, Mueser, Bond, Drake & Solomon, 2007; Davidson, Chinman, Sells & Rowe, 2006), more research is needed before evidence-based

[14] This paper has focused on increasing mental health consumers/persons in recovery in the mental health workforce. However, consumer-operated services are also alternatives and/or complements to the traditional mental health service delivery system. Such services, in addition to increased consumer employment in the existing service system, could also be transformative. Research on consumer-operated services is ongoing and attention to the findings should be considered as the C-RECS moves forward (Campbell, 2004; Campbell, 2005). Numerous consumer-run organizations that assist in workforce development arenas operate nationally. These include the Depression and Bipolar Support Alliance, the Mental Health Empowerment Project, the Consumer Organization and Networking Technical Assistance Center (CONTAC), the National Empowerment Center, Howie the Harp Peer Advocacy Center, and the Kansas Self-Help Network (http://www.selfhelpnetwork.wichita.edu/). In some states, such as New York and New Jersey, the Department of Mental Health has funded consumer-run recovery-oriented services (Swarbrick, 2007). Choice of New Rochelle, for example, provides case management services, shelter outreach, and advocacy services as well as education and training; their leaders offered an USPRA-sponsored workshop in November 2007 called, "Oh, no! We've hired consumers – supporting people in recovery in their roles as service providers."

practices can be determined. According to Davidson, Chinman, Sells and Rowe (2006), "For peer support to move from being a promising practice to one that is truly evidence-based, much work will need to be devoted to developing models, manuals, training curricula, and fidelity measures that will enable us to determine what peer providers do with their own life experiences for whom, under what circumstances, and to what effects" (p. 7). Leff, Campbell, Gagne and Woocher (1997) recommend that peer employment evaluations include a combination of participatory action research and traditional evaluation. Hyde, Falls, Morris, and Schoenwald (2003) stress that "An evaluation plan is needed before implementation of the evidence-based practice begins. The evaluation plan should include identification of the outcomes you want to measure, the data you need to collect, and the methodology and frequency of outcome measurement" (p. 62).

Sustaining funding for employment of persons in recovery in the mental health workforce

In order to assure ongoing employment of persons in recovery in the mental health workforce, adequate, ongoing funding is essential. Emerging practices in this area are described below.

Implement Medicaid-reimbursable services including consumer employees

Through its consumer-led initiatives, Georgia has been the national leader in this regard, beginning with its 20 to Work by 2000 initiative that resulted in creation of the Georgia Certified Peer Specialist program and Medicaid reimbursement for certain peer-provided services (http://www.gacps.org/Home.html; Sabin & Daniels, 2003).

Some other states have adopted or are in the process of adopting this practice (Knight, Belcher & Ashenden, 2006). Connecticut has been working to develop Medicaid reimbursement for certified peer employees as part of the Medicaid Rehabilitation Option. If approved, mandated funding for some peer-provided services will be available..

Provide state funding support for dedicated consumer positions in state-operated and state-funded services

Marrone (2007) emphasizes that mandated funding is essential to develop and sustain employment of persons in recovery. Most, if not all, states have dedicated positions for one or more consumers in their central administrative offices. Information is needed regarding how many states have mandated funding for dedicated consumer positions and/or consumer-run services, along with the titles and numbers of these positions.

Include contractual mandates for specific numbers and proportions of persons in recovery employed in funded agencies.

Consistent with the affirmative action approach in hiring described earlier in this paper, contractual mandates for employment of persons in recovery can assure their ongoing employment (Marrone, 2007). Additional information is needed in this area as well regarding the extent to which this practice is currently occurring throughout the United States and internationally.

Conclusion

The seminal work of Mowbray, Moxley, Jasper and Howell (1997) guided significant evolution in consumer mental health workforce employment during the past ten years. Barrett, Pratt, Basto and Gill (2000) succinctly stated the challenges ahead:

"Consumer providers bring unique benefits to their work… They may face … difficulties such as the stigmatizing attitudes of non-consumer colleagues, or concerns about how job stress may impact their mental illness. Mental health providers and systems that actively recruit consumer providers need to be aware of these issues and should adopt strategies that both provide support and promote integration… In order to develop what Anthony (1993) refers to as a 'recovery vision,' it is not enough to simply hire consumer providers. It is also necessary to support them and encourage them to move beyond second-class, paraprofessional roles into fully integrated professional positions in the service delivery system" (p. 102).

Successfully increasing and maintaining employment of persons in recovery in the mental health workforce requires defining and implementing numerous complex and inter-related strategies, many of which have been described above. As more systems promote and implement employment of persons in recovery and provider organizations increasingly include consumers in their workforce, more research and evaluation will become available on the outcomes of these efforts and on the factors that lead to positive impact for those employed and those who receive services. Mental health systems aiming for proactive transformation are now challenged to move these emerging and promising practices towards demonstrable and replicable best practices and evidence-based practices.

Connecticut is fortunate that grant funding and human resources are available to undertake implementation of its workforce transformation agenda through numerous initiatives, including the creation and operation of the consumer-led C-RECS. The next phase of implementation will require thoughtful strategic and tactical choices to move this agenda forward in specific, measurable ways.

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Resources

Advocacy Unlimited (http://www.mindlink.org)

Bazelon Center for Mental Health Law (http://www.bazelon.org)

Boston University Center for Psychiatric Rehabilitation
http://www.bu.edu/cpr

Central Connecticut State University Central Access and Student Development
http://www.ccsu.edu/casd/

Choice of New Rochelle (http://www.choicenr.org)

Connect-ability http://www.connect-ability.com

Connecticut Network of Care for Behavioral Health
http://connecticut.networkofcare.org/mh/home/index.cfm

Connecticut Legal Rights Project http://www.mindlink.org/clrp.html

Connecticut Recovery Supports Collaborative
http://www.ctrsc.org (this website isn't yet operable as of 9/28/07)

Consumer Organization and Networking Technical Assistance Center (CONTAC) (www.contac.org)
Focus on Recovery-United, Inc. (http://www.focusonrecovery.org)

Georgia Certified Peer Specialist Project http://www.gacps.org/Home.html

Housatonic Community College MERGE Mental Health Certificate Program
http://www.mergementalhealth.org

Howie the Harp Peer Advocacy Center
http://www.communityaccess.org/programs/hth.html

Mental Health Empowerment Project (www.mhepinc.org)

META Services http://metaservices.com/history.htm
http://metaservices.com/Articles/Peer%20Employment%20Training%20History.pdf

META Services Peer Employment Training
http://metaservices.com/peer_support_training.htm

National Alliance on Mental Illness
http://www.NAMI.org

NAMI-Connecticut
http://www.namict.org
(http://www.nami.org/MSTemplate.cfm?Section=For_Consumers&Site=NAMI_of_Connecticut,_Inc&Template=/ContentManagement/ContentDisplay.cfm&ContentID=49439);

http://www.nami.org/MSTemplate.cfm?Section=Programs131&Site=NAMI_of_Connecticut,_Inc&Template=/ContentManagement/ContentDisplay.cfm&ContentID=51277

National Coalition of Mental Health Consumer/Survivor Organizations
http://www.ncmhcso.org

National Empowerment Center (http://www.power2u.org)

National Mental Health Consumers' Self-Health Clearinghouse (http://www.mhselfhelp.org)

Peer Specialist Alliance of America
http://www.peerspecialistallianceofamerica.org/

Psychiatric Rehabilitation Certificate Program (Illinois)
http://www.morainevalley.edu/publicservice/Psych_rehab/PSR.ppt
http://www.morainevalley.edu/programs/general/1445.htm

Recovery Innovations (META Services)
http://metaservices.com/history.htm

South Mountain Community College
http://www.southmountaincc.edu

Southern New Hampshire University Graduate Program in Community Mental Health
http://www.snhu.edu/50.asp

USPRA (United States Psychiatric Rehabilitation Association)
http://www.uspra.org

USPRA Certified Psychiatric Rehabilitation Practitioner
http://www.uspra.org/i4a/pages/index.cfm?pageid=3925

University of Kansas School of Social Welfare Office of Mental Health Research and Training
http://www.socwel.ku.edu/Research

University of Medicine and Dentistry of New Jersey, School of Health Related Professions, Psychiatric Rehabilitation Department
http://shrp.umdnj.edu/programs/psyc/careers.html
http://shrp.umdnj.edu/smi/academic_program/bachelor_science.htm