Consumer-Delivered Services as a Best Practice in Mental Health Care Delivery and The Development of Practice Guidelines

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Consumer-delivered services are receiving increasing attention as an important addition to the continuum of services available to people with a mental illness. This article provides a review of the theoretical and empirical evidence in support of consumer-delivered services as a best practice in mental health service delivery. This is followed by the presentation of proposed guidelines for delivering these types of services that is based on the current literature and the consensus of program directors from the Mental Health Association of Southeastern Pennsylvania, an agency that administers a number of consumer-delivered service programs. These guidelines are intended to assist in the adoption, development, and operation of consumer-delivered services and to aid policymakers and providers in their funding and referral decisions.

Consumer-Delivered Services (CDS) have become increasingly integrated into formal mental health systems and are viewed as an important approach to expanding the continuum of services available to persons with mental illness, including those with serious mental illness. This is partly exemplified, for example, by the recognition of the importance of consumer-delivered services in the recent report, *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 1999). The purpose of this paper is to briefly review the arguments and evidence supporting the adoption of consumer-delivered services as a best practice in the delivery of mental health services and to report the results from initial efforts to develop best practice guidelines for consumer-delivered services. This effort has three goals: 1) Provide information to policymakers and funders that will assist them in making decisions regarding the inclusion of such services in their continuum of mental health services; 2) Offer information to non-consumer agencies and providers who can support the development of such services and make referrals of mental health consumers to these types of services; and 3) Assist consumer-delivered service programs in their efforts to facilitate the recovery of others by providing best practices information that may be useful to them in program development, implementation, and monitoring.

Defining Consumer-Delivered Services

Many definitions of "consumer" exist. For our purposes we define a consumer as someone who has experienced, or is currently experiencing, symptoms associated with a diagnosable mental illness, and has received services to address these symptoms. CDS are those services where identified consumers interact with other identified consumers in services that are uniquely consumer-delivered (e.g., self-help groups) or as part of services that involve both consumer and

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non-consumer staff (e.g., case management). We believe that the sharing of personal experience is a critical element of CDS and is part of what makes them beneficial. It is recognized that many professionals have personal experiences with mental illnesses but choose not to identify as mental health consumers and do not share their personal experiences as consumers. Services delivered by persons who do not identify as consumers or share their personal experiences as consumers would not be considered to be a CDS. A program or agency where consumers serve only as advisors or on a board is also not a CDS.

Many different CDS types have developed over the years. The following typology is useful in appreciating the diversity of these services (see Solomon & Draine, 2001). *Consumer-operated services* are those that are planned, managed, and provided by consumers. *Consumer partnership services* are those in which consumers deliver the services, but the control of the program is shared with non-consumers. *Consumers as employees* reflect services that employ consumers and non-consumers alike. All of these program types can involve paid and unpaid/volunteer consumer roles.

There are an ever-expanding number of programs where consumers play specific roles in service delivery. Self-help groups, also referred to as mutual-help groups reflecting the notion that help is both given and received, are without a doubt the best-known examples of CDS. Alcoholics Anonymous began more than seventy years ago and is now in many countries around the world. Self-help groups for persons with mental illness emerged in the 1950s; examples include Schizophrenics Anonymous, the National Depressive and Manic-Depressive Association, GROW, and Recovery, Inc. More recent groups have emerged for persons with various anxiety disorders, eating disorders, and other mental health conditions. One study in the mid-1990s estimated that 18% of the U.S. population had participated in self-help groups at some point in their lives and almost 7% had done so in the past year (Kessler, Mickelson, & Zhao, 1997). Self-help has expanded on the Internet, including many listservs, chat rooms, bulletin boards, and other Internet communities devoted to peer support around mental health issues (Davison, Pennebaker, & Dickerson, 2000). National and local self-help clearinghouses have been established around the world to disseminate information about the existence and location of self-help group meetings and other types of CDS.

FountainHouse is another well-known example of a CDS. It was founded in the 1950s in New York City by persons with mental illnesses who desired to create a supportive community of peers. FountainHouse gave birth to a clubhouse movement where consumers play active roles in the management and operation of the program. However, with some exceptions, clubhouses have moved from consumer-operated to a consumer-as-employee model, as they now rarely have consumers in prominent management positions.

Drop-in centers differ from clubhouses in the services and programs that are offered and the degree to which they follow a since-codified clubhouse model. Not all clubhouses or drop-in centers are consumer-delivered. Some only have paid consumer roles in, for example, the kitchen or for custodial work, and not for providing any unique support or experiential knowledge beyond the scope of these tasks. Consumers support their peers in these settings, but only in informal ways or through other CDS, such as a self-help group that meets at the facility.

A number of other types of CDS have been developed in local communities and mental health systems. For example, there are a growing number of case management services that are wholly consumer-operated or where consumers are one or several members of a larger case management team (e.g., Chinman et al., 2000; Solomon & Draine, 1995). Consumer staff have also been added to crisis and respite services (e.g., Brown, 1997; Burns-Lynch & Salzer, 2001;

Lyons, Cook, Ruth, & Karver, 1996), vocational services (e.g., Mowbray, Rusilowski-Clover, Arnold, & Allen, 1994), one-to-one peer support programs (e.g., Klein, Cnaan, & Whitecraft, 1998), psychoeducational programs, advocacy, residential services, and supported education.

Consumer-Delivered Services as a Best Practice in Mental Health Care

This is an exciting time in the delivery of mental health services, partly due to the increased attention and commitment to delivering services that are of the highest quality and are likely to be of most benefit to people with mental illnesses (Salzer, Blank, Rothbard, & Hadley, 2001). Evidence-based practices have been defined as "…interventions for which there is consistent scientific evidence showing that they improve client outcomes" (p. 180; Drake et al., 2001). There remains considerable discussion about what types of evidence and how much is needed before an intervention can be touted as an evidence-based practice. Best practices are based on opinions generated from the clinical experiences of practitioners and sometimes research findings, but not always. Drake et al. (2001) point out that best practices based on consensus panels may be best for those areas in which systematic research has not been conducted, thereby preventing a designation of being an "evidence-based practice," but where the practice is still considered to beneficial. One obvious caution is that the practice may not ever be proven effective.

CDS have emerged as a best practice, but cannot yet be considered an evidence-based practice due to insufficient systematic research, based on three factors. First, the various CDS are supported by a solid theoretical base regarding the impact of peer support and social interactions. These theories and a brief description are listed in Table 1.

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Second, there has been a change in service philosophy that has increasingly grown to accept CDS as an important way to expand the continuum of care of beneficial services. As mentioned earlier, the recent Surgeon General's report included a discussion of the role of consumer-delivered services in mental health care delivery. This most recent report expands upon a previous report from a Surgeon General's Workshop on Self-Help and Public Health (1988). This report outlined the benefits associated with self-help as well as strategies for increasing the proliferation of self-help groups as a public health initiative. Further examples of increased acceptance of CDS occurred in 1989, when the National Association of State Mental Health Program Directors took the stance that inclusion of consumers in the provision of direct services should be sought to improve quality of care. State and local mental health systems responded by providing funding to develop and implement CDS. Furthermore, federal, state, and local funding has also been provided for technical assistance centers and clearinghouses to offer technical assistance to self-help groups and other CDS, as well as information about the location of groups to potential participants. Overall, support for CDS represents a mental health system's commitment to a recovery model that emphasizes the development of new meaning and purpose in one's life beyond the constraints associated with a mental illness, resulting in a more satisfying, hopeful, and fulfilling life (Anthony, 1993).

Third, there is a growing, albeit limited body of research that has found consistently positive results for various CDS. Research on CDS has been quite favorable (see reviews by Davdison et al., 1999; Humphreys, 1997; Van Tosh & del Vecchio, 2000). In general, research has shown that the addition of consumer staff in service delivery does not diminish treatment outcomes and

that certain CDS are associated with positive outcomes. For example, studies have shown that consumer-delivered case management is as effective as non-consumer-delivered case management, and crisis teams involving consumers are as effective as those with non-consumers (Chinman et al., 2000; Solomon & Draine, 1995). Consumer-provided vocational services added to usual care is associated with, among other things, higher employment (Kauffman, 1995). However, it is unclear whether or not similar services provided by a non-consumer would be as effective or more effective.

Studies of drop-in centers have shown that they are associated with increased quality of life, enhanced social support and problem solving (Mowbray & Tan, 1993). Research on mental health self-help groups indicate that they are associated with decreased symptoms, increased coping skills, and increased life satisfaction among long-term members versus short-term members (e.g., Davdison et al., 1999; Chamberlin et al., 1996; Humphreys, 1997; Raiff, 1984). One unpublished study found decreased rates of hospitalization for participants in one self-help group versus a matched comparison group (Kennedy, 1989). Research on peer support interventions have also been positive. One study found that case management services plus a peer specialist counselor were associated with enhanced quality of life, fewer major life problems, and greater gains in social support for those receiving such services than for those receiving case management services without a peer (Felton et al., 1995). A study of a one-to-one peer support program for persons with co-occurring mental health and substance abuse problems found that program participants had fewer crisis events and hospitalizations, improved social functioning, greater reduction in substance use, and improvements in quality of life compared to a non-matched comparison group (Klein, Cnaan, & Whitecraft, 1998). Additional benefits, in terms of enhanced recovery and job skills (Salzer & Liptzin-Shear, 2002) and reduced hospitalization (Sherman & Porter, 1991), have also been reported for consumer providers in those CDS where there are more formal provider and recipient roles.

Some professionals have expressed concerns that peer-to-peer interactions may be harmful (e.g., Lee, 1995). In fact, one survey of mental health professionals found that approximately 15% indicated that they would try to convince people attending self-help groups to seek professional help instead (Salzer, Rappaport, & Segre, 2001). However, the current literature does not support these fears, and on the contrary, suggests that CDS are beneficial.

The consistently favorable results for CDS lead to tempered optimism about their effectiveness as the research foundation has significant limitations (see review by Solomon & Draine, 2001), not unusual for a relatively unexplored research area. The current research base is limited by a relatively sparse number of studies, few replications of findings, and limited use of rigorous research designs. An exciting multi-site research initiative funded by SAMHSA's Center for Mental Health Services is currently underway in an attempt to use more rigorous research methods to understand the effectiveness of CDS. This initiative is called the Consumer-Operated Service Program.

Best Practice Guidelines

These guidelines are based on a review of the CDS literature and the perspectives of CDS leaders at the Mental Health Association of Southeastern Pennsylvania (MHASP). MHASP currently administers a number of CDS, including, but not limited to: 1) Friends Connection – a peer support program for persons with co-occurring mental health and substance abuse disorders; 2) Mainstream – a vocational rehabilitation program; 3) ACCESS West Philly – a case

management program for persons with a history of homelessness; 4) TCM SHARE – a case management program; 5) Community Companion – a volunteer peer support program; 6) Unity Clubhouse; 7) numerous drop-in centers; 8) Homeward Bound – a residential program; and 9) the National Mental Health Consumers' Self-Help Clearinghouse, which provides technical assistance and other support to numerous CDS. Consumers have significant administrative roles in MHASP, ranging from program directors to the President and Chief Executive Officer of this almost 310-person organization. Consumers also account for more than 50% of the board of directors.

MHASP established a "Best Practices Team" consisting of representatives from the MHASP programs described above. These guidelines are the result of the following process: 1) Best practices team members were interviewed and submitted written information to ascertain their practices in administering their program; 2) the lead author reviewed the themes and practices of MHASP staff from the interviews and written information they provided, combined them with information derived from the published literature, and initiated the guidelines document; 3) An iterative revision process was employed, during which team members commented on drafts of the guidelines until consensus was reached among all team members.

These guidelines focus on program characteristics that are either unique to CDS or require specific mention. We do not offer guidelines on, for example, how to provide case management or vocational rehabilitation services. Guidelines for these and other program types are available elsewhere and the involvement of consumers does not significantly alter the general philosophies and approaches underlying these programs. Instead, these guidelines target issues that cut across consumer-delivered program types. Specifically, we focus on two areas – practices as they relate to consumer participants and those pertaining to consumer-providers.

Consumer Participant Guidelines

Target Populations – Aside from specific target populations for specific programs, such as the special consumer characteristics targeted by case management, crisis, or vocational programs, CDS are appropriate for most mental health consumers, regardless of diagnosis or history. This includes people with significant challenges as a result of their illness. Self-help groups and drop-in centers have been argued to provide a niche for persons with serious mental illness who have had negative experiences with traditional services and avoid formal care (e.g., Meek, 1994). In this sense, CDS may be particularly important for targeting those who have become alienated from more traditional mental health services and may be their only connection to the mental health system.

Consumer preferences likely play a role in the degree to which people participate in any mental health intervention (see discussion of consumer preferences in Corrigan & Salzer, in press; Ten Have, Coyne, Salzer, & Katz, in press). Preferences for CDS is likely the single most important factor in assessing whether or not someone will want to become involved in a CDS. CDS are not desired by everyone even when consumers are referred and encouraged to attend. For example, one study found that only 17% of 45 people randomly assigned to participate in a self-help group did so (Kaufmann, Schulberg, & Schooler, 1994). Another study found that only 42 out of 62 participants with depression (approximately 67%) met with a peer supporter after being assigned one by a primary care provider. Approximately half of the participants who did meet with a supporter had only one or two contacts (Hunkeler et al., 2000).

Contraindications for use – There are no clear contraindications for participating in CDS other than contraindications for specific program models. For example, people with no interest in work will likely not benefit from a consumer delivered vocational rehabilitation program.

However, people with significant interpersonal conduct and communication problems, including a history of violence, may not be appropriate for those CDS involving considerable independence (e.g., self-help groups, drop-in centers). For example, people with significant interpersonal communications problems may be less able to contribute to interactions during self-help group meetings and would therefore obtain fewer benefits. Drop-in centers, on the other hand, can be ideal for people with significant interpersonal difficulties because there is a wide degree of flexibility in how much they participate in activities and what types of interactions they have with others. But these programs allow for a great deal of independence and self-direction, and less supervision from drop-in center staff, which may mean that staff will not be available to de-escalate situations with the potential for conflict, though this may be a role filled by members of the programs.

Implementation Steps – Paths to the successful development and implementation of CDS are as varied as CDS themselves. CDS have developed both from within and outside the mental health system. Self-help groups are the best example of CDS that have developed and prospered outside the mental health system. Self-help groups consist of persons who have come together in response to various distressing situations, such as the personal experience of an illness or the illness of a loved one. Self-help group leadership and direction come from within the group. Professionals play minimal roles, including referring persons to groups, helping to organize groups, providing space for groups to meet, and occasional assistance in dealing with specific issues. One exception to this general rule is Alcoholics Anonymous and other substance abuse 12-step groups that have become increasingly incorporated into behavioral health care service systems.

Other CDS, especially those where consumers are employees in services that are also delivered by non-consumers, are frequently developed and implemented within the mental health system and receive substantial financial support. The success of these CDS is furthered by non-consumer professional collaboration and support that appreciate the unique contributions that consumers can make in these programs. Such support should also be sensitive to the unique operations and benefits of these programs and avoid situations and demands that might lead to changes in critical aspects of CDS programs. CDS that depend too heavily on professional involvement and financing are at risk of losing their unique qualities and benefits. For example, self-help groups that become overly dependent on professional assistance may find that group members are less likely to assume leadership roles and that the initiative needed to help the group survive is diminished. Such groups may be more likely to disband. Communication among consumers and non-consumers is critical to prevent changes that diminish the unique qualities of CDS. These unique qualities are what make them an important addition to the continuum of services.

Level of Involvement Recommendations – There are no general involvement or participation recommendations for CDS, again, other than recommendations that may exist for specific programs and program types (e.g., case management, vocational rehabilitation). The lack of a general involvement guideline is consistent with the principles of choice and self-determination that are important features of CDS.

Despite the lack of specific dosing recommendations, there is some research indicating that greater involvement is associated with better outcomes. Galanter (1988) found improved

psychopathology, increased coping skills, and increased life satisfaction among long-term versus short-term members of Recovery, Inc., a self-help group for people with severe mental illnesses. A study of GROW, also a self-help group for people with severe mental illnesses, found that more group attendance was associated with lower levels of isolation and brooding, and increased support seeking (Reischl, 1988). There is similar evidence of dose-response relationships in peer services for people with co-occurring mental health and addiction disorders. Gonzalez and Rosenheck (2002) reported results from over 4,000 people involved in the Center for Mental Health Services' Access to Community Care and Effective Services and Supports program for homeless people with severe mental illnesses and co-occurring addiction disorders. They found that greater participation in self-help groups among those with co-occurring disorders was associated with better outcomes. Finally, a study of 310 people with co-occurring disorders found that those with more participation in self-help groups for people with co-occurring disorders (i.e., Double-Trouble groups) reported less substance use and mental distress and greater levels of well-being (Laudet et al., 2000). Of course, such an apparent "dose-response" relationship might result from more motivated people being more likely to attend more often *and* being more likely to make other significant changes in their lives that accounts for more positive outcomes. Nonetheless, it is still believed that even infrequent participation may be beneficial as a result of interacting with others who provide examples of empowerment, hope for recovery, and a model for how to achieve recovery.

Monitoring of progress and problems – Specific programs have their own unique methods, including formal and informal methods, for monitoring side effects, progress, and individual problems. Programs where consumers serve as employees should have formal procedures for this ongoing monitoring that are consistent with the program type. For example, case management teams involving consumer-providers should have a process for conducting reviews of participant status and progress, as well as goal planning. However, other CDS, including self-help groups and drop-in centers, do not adopt a "treatment" orientation, do not generate and keep individual treatment plans and records, and do not formally monitor side effects, progress, and problems. Informal monitoring often occurs, however. It is not uncommon for self-help group members to speak with another member either as a group or individually if it is felt that the person is having a particularly difficult time. Drop-in center staff or individual participants may similarly speak with a drop-in center participant if they feel that person is not doing well. Informal support may include the provision of emotional support, information, or encouragement to speak with mental health professionals about problems.

Gender and cultural issues – The power of interactions between those with similar or shared experiences is one of the key principles underlying CDS. Gender and cultural factors, as well as diagnosis, personality, interests, and mental health experiences, are important factors that may influence the extent to which CDS are beneficial to a particular individual. Poor matches or "fits" will occur and can diminish the connection made between consumers. CDS that have only one or two consumers involved in service delivery are obviously limited in the extent to which they can make changes to improve a particular match. Differences that may interfere with the development of a positive relationship should be considered and discussed as appropriate.

Gender and cultural issues are particularly important for any program. CDS emphasize acceptance and cultural sensitivity as core values. Guidelines have also developed over time for how to address gender and cultural issues in self-help groups and one-to-one peer support. Self-help groups often include both sexes, but there are also many same-sex groups for those who desire such groups. Group members often have enough similar experiences to promote

connections and a sense of community. They also encourage connection through respect for diversity and have enough common ground within group diversity that friendships among specific members can develop. However, the self-help group movement has been criticized for not promoting enough cultural diversity among group members, especially among non-Whites and low-income persons. There is an increase in self-help groups involving a greater percentage of non-Whites, but more effort is still needed to expand in this direction. An individual's fit with a particular group culture may not always be a good one. Potential self-help group members should be encouraged to attend different groups, assuming there is more than one local group pertinent to their issues, until they find one that they feel comfortable with.

One-to-one peer support programs will often match peers on the basis of gender and attempt to match them on the basis of culture as much as possible to increase the similarity of personal experiences. Same-sex matching among heterosexual participants will also inhibit the occurrence of sexual relationships, an issue discussed in more detail later in the section on dual relationships. There is no perfect or generalizable formula for producing successful matches in peer support programs. For example, matching persons from similar cultures may be less important in some cases than matching on similar illness characteristics or addictions. Successful programs monitor the extent to which interpersonal relationships seem beneficial and will make changes if the match is perceived to be inadequate.

Consumer-Provider Guidelines

The following issues generally pertain only to CDS that involve paid consumer-providers. Consumer-provider guidelines are similar to guidelines for non-consumer staff of any program. Hiring, training, and supervisory issues do generally not affect self-help groups and other programs involving consumer volunteers. However, all CDS (and non-CDS for that matter) are affected by dual relationships, including sexual relationships, confidentiality issues, and role conflicts. *Consumers as Providers in Psychiatric Rehabilitation* (1997), by Mowbray and colleagues, is an excellent additional resource for understanding the experiences of consumer providers and how the following guidelines may be useful in enhancing their experiences in the service delivery system.

Hiring – Recruitment of paid consumer-providers is frequently done through advertisements placed in mental health agencies and other venues where consumers may congregate, as well as in newspapers. Advertisements generally include statements such as "Current and former mental health consumers encouraged to apply." Substantial recruitment also occurs through word of mouth and conversations among consumers.

CDS involving paid positions generally require at least a high school education to ensure that the employee has some degree of ability to complete paperwork and meet minimal job demands. Volunteer CDS programs generally do not have education requirements. Skills and education may become a bigger issue in the future for CDS that are able to obtain Medicaid and other forms of reimbursement (e.g., managed care). Reimbursement often requires being added to a provider panel that has requirements, such as the need for staff with degrees, certification, experience, and training that are thought to be associated with the provision of a higher quality of care. Such requirements will severely limit the pool of potential consumers who are eligible to be hired. The demand for more formalized education and skills may be important as a strategy for eliminating persons from the hiring process who may not have sufficient work skills (e.g., ability to do paperwork, maintain attendance, follow directions). This may be an issue for both consumers and non-consumers, but it is not consistent with theories underlying CDS that

emphasize experiential knowledge of mental illness and the benefits of sharing this knowledge and experiences with others. More stringent personnel requirements may alter the nature of CDS and diminish their unique benefits.

The work demands and expectations of people hired as peer support staff or counselors should be made clear during the interview process prior to be hired. Specifically, people should know ahead of time what is expected of them in terms of disclosure of their own personal information to other staff as well as to other consumers. For example, a person being interviewed for a position would need to know that they might be asked to provide a "consumer perspective" during team meetings or to supervisors, and that they might be asked to share their personal experiences with treatment with program participants.

Training – Programs involving paid consumer-provider staff should have specific training procedures outlining the mission, philosophy, goals, and procedures associated with the delivery of the program. Exceptions to this are CDS involving non-paid persons, including self-help groups and similar voluntary CDS programs, especially those emphasizing companionship. However, even these latter types of programs could benefit from informal training on leadership, organizational, and listening skills. Specific topics for paid consumer-providers should include a discussion of how they can use their personal experiences to build empathy with program participants, and provide emotional support, informational support, and validation. Additionally, training should involve a discussion of issues that might arise in their interactions with non-consumer staff and consumers, especially topics such as dual relationships, role conflicts, and confidentiality, discussed in the next section.

Supervision – As with any human service program, good supervision and monitoring is essential. Such supervision ensures that the program is being delivered with some degree of fidelity and is useful for addressing any issues that may arise, especially personal and interpersonal issues that may affect an employee's performance or the performance of the program as a whole. Frequent team meetings and individual supervision are beneficial in this regard. Personnel manuals should also thoroughly describe rules and procedures to assist all employees and supervisors in their interactions.

CDS should be particularly sensitive to providing accommodations that are consistent with the Americans with Disabilities Act. While accommodations might not always be necessary, supervisors should provide an environment for discussion of personal and professional issues that might interfere with work and do everything possible to address any issues that arise. Supervisors should also be proactive in discussing dual relationships, role conflicts, and confidentiality.

Dual relationships refers to the existence of more than one relationship, professional, social, personal, business, or financial, between an individual and another individual or an organization. In general, health care services have adopted the ethic of limiting the potential for harm in service delivery. Dual relationships have been discouraged by many healthcare professions to limit the extent of real emotional or physical harm or exploitation of program participants or the appearance of potential for harm or exploitation. Multiple relationships are a fact of life. Specific concerns related to consumer-providers are the existence of past or current relationships between the consumer-provider and the employing organization or non-consumer staff (e.g., the consumer has received services from the organization), and consumer-provider relationships with other consumers participating in the CDS. There are no hard and fast rules for how to deal with dual relationships. The following alternatives might be used to address this issue.

The following are a number of excellent suggestions for dealing with dual relationships in CDS offered by Carlson, Rapp, and McDiarmid (2001). In large urban areas, consumer-providers could be hired from outside a particular agency, or an agency could require that consumer-providers obtain care from another provider. The former strategy is problematic because it prevents persons from within a particular agency from working in that agency's CDS. The latter solution may be particularly challenging because it could disrupt established care relationships, and it may be nearly impossible for persons residing and receiving treatment in rural areas to find another provider. The most promising and acceptable strategy may be that supervision and persons with whom the consumer-provider does not have a dual relationship should conduct personnel matters.

Dual relationships with consumer participants are also a concern. Consumer-providers should not be required to sever ties with consumer participants who have become an important part of their social network. However, a number of strategies can be used to diminish potential conflicts that might occur. First, those programs that match consumer-providers with a specific consumer participant should avoid matches when a dual relationship involving close, personal contacts has been established. Second, matches should be avoided with persons who reside in the same housing situation or program. Third, supervision should include monitoring of dual relationship issues that might arise over time and steps should be taken to actively address these issues.

The existence of sexual or dating relationships is a particularly important issue to address. Again, these issues are not unique to consumer-providers, as all mental health disciplines struggle with the establishment of professional rules of conduct for effectively dealing with these potentially harmful relationships in service delivery situations. Active sexual or dating relationships are prohibited in more formal CDS, and past relationships prevent the consumer-provider from offering direct services to a person with whom he or she had such a relationship. CDS that are less formal and involve voluntary participation, such as self-help groups, sometimes overtly discourage sexual relationships or dating among members, while others allow discreet romantic relationships. Most recognize that romantic relationships may overly complicate the peer support that is provided and increase the chances that negative or harmful interactions will occur. Sexual relationships are a natural part of healthy interpersonal relationships, but are not part of the mission of one-to-one peer support programs or self-help.

Role Conflicts and Confusion refers to issues that arise for the consumer-provider as a result of assuming an identity that combines their experiences as a consumer with the role of a provider of services. Conflicts with non-consumer staff may arise if consumer-providers are treated as if they are of lesser importance or have less to offer in terms of providing a beneficial service. Non-consumer staff may also treat consumer-providers as ancillary staff who are less than equal in terms of skills and ability. Non-consumer staff may even assume the role of "therapist" with consumer staff. These relationships are obviously harmful to all persons involved and can undermine the success of CDS. Consumer-providers are also challenged by the need to balance their consumer and provider identities. That is, they may not be accepted within the provider community as full-fledged providers and no longer accepted as consumers among peers.

Carlson, Rapp, and McDiarmid (2001) also offer excellent solutions for addressing these issues. One solution to role conflicts and confusion includes the clear specification of roles and responsibilities of consumer and non-consumer positions. This will assist the consumer-provider in clearly understanding their roles and duties and highlight to other staff that the consumer-provider role is an integral and valued part of the service being provided. Consumer-providers

may also experience difficulties in regard to advocating for a consumer participant's needs that are viewed to be in conflict with agency or program goals or with those of non-consumer staff. These situations should be closely monitored by a respectful and open-minded supervisor to ensure that the consumer-provider feels comfortable expressing their perspective -- a potential goal of the agency in hiring the consumer-provider in the first place -- and that non-consumer staff are not threatened or respond in a hostile way. Conflict resolution strategies should be considered in extreme cases and both parties should be encouraged to respect the team decision-making process and conclusions. Other solutions include: 1) Creating an atmosphere within the agency and programs that respects the contributions made by consumer-providers and encouraging dialogue with those who have concerns about consumer-providers; 2) Providing supervision where these issues are respectfully addressed; and 3) Respecting the right of consumer-providers to choose how much of their personal experience they will disclose to other staff and not publicly requesting that they share personal experiences with others or provide the "consumer perspective" on issues.

Confidentiality concerns include the disclosure of personal information about the consumer-providers to their colleagues and the consumer-provider's breaching a consumer participant's confidentiality. As discussed earlier, consumer-providers should not be forced to disclose personal information to others, and such information, if shared with a supervisor or colleague, should not be freely disclosed to their colleagues or others in the agency or program without permission. Gossip among colleagues is common, but consumer-providers are particularly vulnerable because the voluntary sharing of their experiences is done within the context of their position and attempts to help others. Gossip can be damaging to anyone; but such gossip may undermine the consumer-provider's willingness to disclose to others in the future, which might limit the benefits associated with their involvement in the service delivery system. Supervisors should also be sensitive about releasing information about the exacerbation of an illness or hospitalization of a consumer-provider. Such discretion is important in any employee-employer relationship.

Concerns about breaching the confidentiality of a program participant are a concern for any mental health provider. Major confidentiality violations are not an infrequent occurrence. A chart with a consumer's name is occasionally left out in view for many to see. Information is divulged to others without a signed release of information, or information is divulged that falls outside the scope of information where permission has been given. The most frequent violation may be the use of last names in public waiting rooms and personal conversations that take place in clear earshot of others.

One might argue that consumers may be more sensitive to confidentiality issues than providers are because of consumers' personal experiences. Nonetheless, concerns about consumers' breaking confidentiality have been identified as a major barrier to consumers' being hired in certain organizations. A reasonable argument could be made that while consumer-providers may be sensitive to the issues, they have not likely received the same amount of training on what is confidential and how to maintain confidentiality. Also, consumer-providers may not have thought about whether or not they can discuss information about a program participant that they obtained outside of the service settings. Such disclosure may increase their role conflicts with other consumers, who may begin to distrust the consumer-provider as someone who might share information about them that they did not want to share with the program or agency.

Consumer-providers should be able to maintain social relationships, but also boundaries between work and peers. As with almost all situations, clear policies and procedures regarding confidentiality should be written, and confidentiality issues for everyone in the agency should be openly and frequently discussed among team members and supervisors. Consumer-providers should adhere to confidentiality principles that all agency staff abide by. Similarly, consumer-providers can socialize with peers, but should obviously refrain from disclosing information about program participants and should convey this to others. Consumer-providers should refrain from sharing personal information about others with program or agency staff that was obtained through social rather than work interactions even if such information is important clinically. Moreover, they should inform program participants that even though they are peers, they are obligated to report relevant personal information to other providers.

Creating a Positive CDS Environment – The inclusion of CDS into the continuum of care challenges beliefs about who can provide services and what services are beneficial and important to persons in recovery. Research indicates that non-consumer staff generally believe that self-help groups, and likely other CDS, can be helpful, but there is also a substantial minority who do not feel this way and who may create a hostile, non-collaborative environment (Salzer, Rappaport, & Segre, 2001). In addition, even among the vast majority who do believe that CDS are helpful, many still perceive non-consumer-delivered services to be more helpful, which leads to CDS being viewed as less important or ancillary to the promotion of mental health.

Non-consumers should receive training on the unique benefits associated with CDS and should be provided with opportunities to observe and participate in CDS programs as much as possible. This could include attendance at self-help groups or drop-in centers, as well as joining consumer-providers for a day as they provide services. Agency administration and staff need to be respectful to all employees regardless of level of training, discipline, or consumer status, and should be encouraged to discuss issues that might disrupt full support for CDS. Such concerns may include perceptions that consumer-providers may somehow harm program participants or divulge confidential information, as well as fears that consumer staff might someday replace non-consumer staff.

A positive environment for consumer-providers must also be created to combat the challenges and barriers discussed earlier. Supervisors should create opportunities for issues and concerns to be openly discussed as part of the supervision process as well as in teams. The agency should promote acceptance and provide education about consumer staff and their unique contributions without breaching or requiring loss of privacy. Additional agency support for consumer-providers might include special support, assistance, and mentoring from an agency staff person not affiliated with the specific CDS. This may be particularly helpful to a consumer-provider who has justifiable concerns about expressing problems, especially with their program supervisor. Finally, an agency might consider providing opportunities for consumer-providers to get together and provide support to one another as peers.

Summary

This is an important moment in the history of the development of consumer-delivered services. The current health care delivery environment is increasingly skeptical about the extent to which traditional services can address health problems and more willing to consider alternative treatments. Mental health care providers and funders may be more favorably inclined toward supporting the development of consumer-delivered services as adjunctive and alternative

services to expand the continuum of services that are traditionally offered. The literature reviewed in this article provides documentation in support of consumer-delivered services as a best practice in the delivery of mental health services that, given more systematic research support, might eventually be viewed as an evidence-based practice. We also recognize that practice guideline information may be valuable to CDS providers' efforts to improve services and a tool for other providers and funders to use in gauging CDS providers' attention to quality. We have pulled together information from the growing research and practice literature pertaining to consumer-delivered services and combined it with the expertise present at a large agency that has substantial experience in delivering such services. The resulting guidelines are a starting point and are expected to advance the delivery of CDS and support for such services.

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Author's Note

Table 1. Psychological Theories Underlying Benefits of CDS

Social Comparison Theory (Festinger, 1954)	People seek out interactions with others who have similar experiences.
	Upward comparisons increase self-improvement (e.g., develop skills) and self-enhancement (e.g., increase sense of hope and decrease fears) efforts.
	Downward comparisons are ego enhancing and maintain positive affect by providing examples of how bad things could be.
Social Learning Theory (Bandura, 1977)	Behavior change is more likely when modeling is provided by peers than non-peers.
	Peers model coping and health-enhancing behaviors.
	Peers enhance self-efficacy that one can change behavior.
Social Support Theories	CDS increase support networks, receipt of supportive behaviors, and perceptions of support.
	There are five types of support: 1) Emotional (someone to confide in, provides esteem, reassurance, attachment and intimacy); 2) Instrumental (services, money, transportation); 3) Informational (advice/guidance, help with problem-solving and evaluation of behavior and alternative actions); 4) Companionship (belonging, socializing, feeling connected to others); and 5) Validation (feedback, social comparison).
Experiential Knowledge (Borkman, 1999)	Experience with an illness leads to an understanding and knowledge base that is different from that acquired through research and observation.
	Experiential knowledge leads to different intervention approaches.
Helper-Therapy Principle (Riessman, 1965; Skovholt, 1974)	Helping others is beneficial: 1) Increased sense of interpersonal competence as a result of making an impact on another's life; 2) Development of a sense of equality in giving and taking between himself or herself and others; 3) Helper gains new personally relevant knowledge while helping; and 4) Helper receives social approval from the person they help and others.