The Personal and Vocational Impact of Training and Employing People with Psychiatric Disabilities as Providers

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Objective: *This study examined the feasibility of a structured peer provider training program and its effect on peer providers with respect to their own personal and vocational recovery.* Methods: *Sixty-six individuals participated in an evaluation of a 60-hour, 5-week long peer training program. Participants were assessed prior to and after the training on scales to measure recovery, empowerment and self-concept. Analyses of variance were used to examine subjective changes in these measures. Job acquisition and retention data were also examined at posttest.* Results: *Participants experienced gains in perceived empowerment, attitudes toward recovery and self-concept. Trainees went on to obtain peer provider positions within the mental health agency in which they received the training and 89% of those trained retained employment at 12 months. Twenty-nine percent of the initial jobs into which the peer providers were placed were full-time; 52% were part-time and 19% were hourly.* Conclusions: *Findings suggest that a standardized program designed to provide peer training was used successfully and participants' recovery and employability were improved. Further studies are recommended to rigorously test peer providers' impact on their clients and to examine the advantages that accrue to the agency when mental health recipients are employed as peer providers.*

Introduction

The employment of people with psychiatric disabilities as providers may be a critical pathway for increasing consumer involvement in the mental health system (New Freedom Commission on Mental Health, 2003). This notion has rapidly been gaining acknowledgement as a promising modality that can augment traditional mental health services (Campbell, Johnsen, Lichtenstein, Noel, & Sonnefeld, in press). Providers who have been service recipients can expand the range and availability of services, engage more individuals in services, and facilitate their own rehabilitation and recovery as well as the recovery of other people with similar disabilities (Clay, Schnell, Corrigan, & Ralph, 2005; New

Freedom Commission on Mental Health, 2003).

Furthermore, transformation to a mental health system where service delivery is no longer driven solely by the values of professionals and bureaucrats, but rather is based on an equitable partnership involving individuals with psychiatric disabilities is needed (Clay et al., 2005; New Freedom Commission on Mental Health, 2003). One way to achieve such a transformation and partnership is through the employment of people who are consumers of mental health services as providers, a goal stated by the President's New Freedom Commission (New Freedom Commission on Mental Health, 2003).

Advantages to Peer Providers

Obtaining employment as a provider of mental health services has many well-documented, legitimate advantages to the employee (Carlson, Rapp, & McDiarmid, 2001). Decades ago Pearl & Riessman (1965) advanced the notion of the "helper therapy principle" which maintained that people who help others are in fact, helped themselves. Research over the last several decades has rarely researched the validity of that principle for people with severe mental illnesses who function as helpers (Barrett, Pratt, Basto, & Gill, 2000). Application of the helper- therapy principle to peer providers who have psychiatric disabilities suggests that training and employing peers as helpers would positively affect them both vocationally and psychologically. Employment can provide an identity shift from patient/consumer/client to that of valued worker and contributing citizen. Assisting people to become peer providers can have a profound effect upon the person and their personal process of recovery.

The literature suggests that benefits accrue both intrapersonally and interpersonally to peer support providers. The role of peer provider is experienced as critical in facilitating the growth of self-esteem that is essential in the healing process (Copeland, 1997; Deegan, 1994; Moxley, 1994). People working as peer providers often re-conceptualize their identity from someone who is ill, incapable, disabled and disempowered to one who is legitimate, empowered and validated (Breton, 1991; Cox, 1991; Mowbray, Moxley, Jasper, & Howell, 1997). Indeed, people experience positive changes in self-esteem, empowerment, hope, coping skills and community integration (Carlson et al., 2001; Mowbray & Moxley, 1997a).

Another highly visible advantage of training people to be peer providers is the tangible benefit of productive and meaningful employment (Rifkin, 1996). Employment as a peer provider gives individuals jobs that bring with them financial remuneration, and opportunities for skill development, mobility, and career advancement (Mowbray & Moxley, 1997b).

Advantages of Peer Providers

Training and employing people with psychiatric disabilities as mental health providers can have multiple advantages, including advantages to the person trained, their clients, and the program and system in which they work. Peer and mutual support programs led by peer providers have a long history in the treatment of substance use disorders (e.g., Alcoholics Anonymous), more recently in psychiatric disorders with the advent of Schizophrenics Anonymous (Mowbray et al., 1997; Schizophrenics Anonymous, 1992) and in the myriad self-help offshoots based upon the "12–step" model of intervention. These programs provide some evidence for the importance of having "recovering" peers as providers, role models and guides.

Results of nonrandomized studies have suggested that among recipients of peer support, decreases in psychiatric symptoms and hospitalizations were found (Galanter, 1988). In addition, studies have found larger social support networks (Carpinello, Knight, & Janis, 1992; Rappaport et al., 1985), enhanced self-esteem and social functioning (Kaufmann, 1994; Markowitz, DeMasi, Knight, & Solka, 1996) and improved well-being among recipients of peer support or mutual aid (Davidson et al., 1999). However, it must be noted that these conclusions are based on uncontrolled studies or demonstrations of providing peer support (Campbell et al., in press; Davidson et al., 1999; Segal, Silverman, & Temkin, 1995; Solomon & Draine, 2001).

An agency (and the larger system in which it functions) could potentially receive a number of benefits by employing trained and effective peer providers. By increasing their trained peer personnel, an agency can increase the number of people served and their own cost-effectiveness due to the flexibility in scheduling and organizational commitment that is often inherent in the employment of peers (Basto, Pratt, Gill, & Barrett, 2000; Carlson et al., 2001). Additionally, by employing peer providers, the agency/system is creating a culture that recognizes people with disabilities as help-providers rather than as help-receivers. Peer employees can be an observable message of the agency's growth-oriented mission (Mowbray & Moxley, 1997a; Shepard, 1992). Furthermore, for the trained peers themselves, one would expect a lowered use of more costly services, such as day treatment and inpatient (Sherman & Porter, 1991), thus having an overall positive effect on the system in which they are employed.

Few programs have embarked on a peer support training program with a

standardized training program. We sought such an undertaking in this study. The goal of this evaluation was to describe and evaluate the effects of a peer provider training and employment program on the peers' personal and vocational recovery. We expected that these results could serve as a foundation for further investigations of the benefits of this peer training initiative on the individuals and the agency/system in which the peer providers are employed. The study was conducted at META Services, Inc., a large community based mental health agency located in Phoenix, Arizona. META began to transition to recovery-oriented service provision in 1993 and hired its first peer providers in 1998.

Method

Recipients of mental health services were recruited and trained to provide peer support services. Using a pre-post design, evaluation of peer support specialists' experiences were accomplished by administering pre- and post-assessments along various domains. In addition, we captured the qualitative experiences of participants by obtaining personal narratives of their experiences.

Participants

Demographic information about study participants was collected on trainees' application forms. The greatest number of training participants (38%) report being referred to the Peer Support Training Program by their VR counselors, their DMH case manager (20%), self-referral (12%), or by a META staff person (9%). The remainder were referred by a variety of sources such as their psychiatrist, their social worker, or another META participant.

With respect to mental health status, diagnoses were self-reported by participants. Up to 4 psychiatric diagnoses could be reported. In order to deter-

TABLE 1—DEMOGRAPHIC AND CLINICAL CHARACTERISTICS OF THE TRAINEES

Demographic Variable	Percent in each category
Gender	
Female	65%
Male	35%
Race	
White	80%
Non-white	20%
Education	
Graduated from college	18%
Attended college	53%
Did not attend college	29%
Primary Diagnosis	
Schizophrenia-spectrum disorder	23%
Bipolar	45%
Depressive disorder	30%
Other	2%
Taking Psychiatric Medication	
Yes	93%
No	7%
Type of Psychiatric Medication*	
Anti-depressant	73%
Anti-psychotic	58%
Anti-anxiety	32%
Hypnotic	10%
Residential Status	
Living Independently	79%
Supported Housing	6%
Supervised Residential Housing	8%
Other	5%
Homeless	3%
Benefits*	
SSDI	56%
SSI	25%
Veterans benefits	5%
General assistance	2%
Assistance from family members	17%
Other Medical Conditions*	
Cardiovascular disorder or high blood pressure	17%
Substance abuse problems	17%
Obesity	17%
Learning disability	12%
Rheumatoid or osteoarthritis	12%
Diabetes	12%
Visual impairment	11%
Respiratory problems	9%
Seizure disorder	6%
Muscular-skeletal disorder	5%
Hearing impairment	5%
Traumatic brain injury	3%
Eating disorder	3%

*Total exceeds 100% for these variables because individuals were allowed to select more than one response

mine the primary diagnosis, we assumed that if an individual had a diagnosis of schizophrenia or schizoaffective disorder, that diagnosis would become their primary diagnosis, regardless of other diagnoses (if others were reported) because of the severity of disability generally associated with that disorder. If participants did not report a disorder of schizophrenia, then a diagnosis of bipolar disorder would similarly become their primary disorder. Depressive disorders were next in terms of severity, followed by anxiety disorders and other disorders, usually Axis II disorders such as borderline personality disorders. Using this approach, we found the primary diagnoses that appear in Table 1.

We also inquired about other medical conditions which appear in Table 1. Participants were asked about the number of psychiatric hospitalizations they had had in the past 2 years. A total of 44% reported no hospitalizations. Of the 66% who reported a hospitalization, the majority reported either one or two hospitalizations (69%). Of the remainder, there were between 3 and 15 hospitalizations reported in the past 2 years. Nine individuals did not answer this question. Individuals report the number of days hospitalized as between 1 and 270, with the median falling at about 14 days. In terms of age at first contact with psychiatric care, individuals reported between the ages of 5 years old and 65 years old, with the median being at approximately 21 (10 individuals did not answer this question). Approximately 25 individuals report having been arrested between 1 and 20 times; however, since over half of the respondents did not answer this question, these data are difficult to interpret.

Procedures

The Peer Educator Training program was offered by META Services Inc., to all mental health consumers in the Phoenix, Arizona catchment area. There was no formal screening for the program except for an expressed desire to participate. Sixty-six individuals from a total of 141 trainees (47.5%) agreed to participate in the evaluation and had complete pre- and post-data (the remaining individuals chose not to participate in the evaluation). Participants were drawn from 9 classes that spanned 14 months and were administered baseline instruments prior to beginning the classes and posttests at the conclusion of the training. Administrative data were collected to verify vocational outcomes. All data were coded, entered, analyzed and interpreted by the Center for Psychiatric Rehabilitation at Boston University.

Intervention

META Services, Inc. developed a 60-hour intensive training for persons with psychiatric disabilities who wish to work as peer providers. The Peer Support Training program develops a learning community where individuals are encouraged to engage in a process of self-exploration, growth and acquisition of knowledge about recovery from mental illness. The curriculum is a mix of information, knowledge and skill development utilizing adult learning theory and direct skill teaching approaches (Cohen, Danley, & Nemec, 1985).

For this study, individuals completed the Peer Support training during a 5-week period in which classes met 3 days a week in a classroom located within the agency. Each class met for 4 hours with two scheduled 10-minute breaks; class sizes ranged from 11-19 participants. There were two instructors during this training, both of whom experienced a psychiatric disability. Both instructors had college degrees with no formal training as educators. The training was implemented in a standardized way in that the instructor remained the same during all rounds of training and the curriculum was offered in the same sequence with the same process and assignments. The training manual was revised slightly after each use or iteration however, to reflect slight refinements in the teaching process and the content.

Four tests and four quizzes utilizing short answers and true-false items are used to measure if participants understand the written material and class lectures. Participants must achieve an 80% average to graduate from the program. A participant is allowed to miss 8 class hours. If more than 8 hours are missed, participants are invited to restart with the next class. Areas in which the participants are required to gain mastery include: ethics and boundaries, conflict resolution, cultural diversity, Wellness Recovery Action Plan for Work (Copeland, 1997), suicide prevention, communication, listening skills, community resources, resilience and emotional intelligence (Goleman, Boyatzis, & McKee, 2002). Each student participates in role-plays to practice their skills. Moreover, as participants engage in the learning community, spontaneous practice of their learned skills takes place in an atmosphere of mutual support. Positive support is provided to all participants and cognitive-behavioral strategies such as homework are utilized (Seligman & Csikszentmihalyi, 2000).

In addition to the structured activities described, participants are educated about the values and principles of recovery and the process of recovery from mental illness. Participants are exposed to personal narratives of other people in recovery from serious mental illness and share their own stories of recovery with one another. At the successful completion of the program, participants receive 4 college credits through a local community college. In addition, a graduation ceremony occurs and each class member receives a

certificate of completion of Peer Support Training.

META Services, Inc. offers employment to individuals as *peer support specialists* upon the completion of the training. The agency receives payment for training potential staff, and hires staff only after they have completed the peer training. Job accommodations are made as needed and include lateral moves within the company to find a better match, redirecting and additional time to complete tasks. Peer support providers at META are held to the highest standards of professional ethics, and there have been a few employment terminations due to people's inability to meet those standards. Peer support providers are screened for past criminal activity and if they do have a criminal record, they are hired into only those programs where there are not minors and where they work as a group, rather than alone in unsupervised settings.

Measures

Demographic data were collected at referral. A participant's employment status after completion of the training program was verified through the agency's employment records, as all the study participants who completed the training were then employed by META in peer provider positions. Several standardized tests to measure various facets of recovery, empowerment and self-esteem were administered immediately prior to and following the training. The instruments in this program evaluation were chosen because they measure concepts and/or knowledge and attitudes described in the professional and consumer literature as central to the experience of recovery and were developed with significant consumer input (Deegan, 1994; Mowbray & Moxley, 1997a; Silverman, 1997).

Empowerment Scale. The Empowerment Scale is a 28-item instrument designed to measure subjective feelings of empowerment in which respondents answer questions on a four-point scale ranging from Strongly Agree to Strongly Disagree. The scale was developed to reflect a consensual definition of empowerment developed by consumers of mental health services and has been demonstrated to have good consistency and internal reliability, as well as good factorial validity and known groups validity (Rogers, Chamberlain, Ellison, & Crean, 1997). Recent analyses from a multi-site study of persons with serious psychiatric disability confirm the scale's good internal consistency and convergent validity; however, additional factor analyses suggest a different factor structure with this large cohort of 1,800 individuals (Rogers, Ralph, Salzer, DeForest, & Sangster, under review).

Recovery Attitudes Questionnaire-7. The Recovery Attitudes Questionnaire has seven items measured on a five-point Likert Scale ranging from Strongly Agree to Strongly Disagree (Borkin et al., 2000). The scale is designed to measure two factors related to recovery: 1) recovery is possible and; 2) recovery is difficult and it differs among people. Test re-test reliability, internal consistency and factorial validity were established after administering the instrument to 868 individuals with serious mental illness, providers of mental health services and the general public (Borkin et al., 2000). The authors began with a 21-item scale that demonstrated an acceptable level of internal consistency (.84 coefficient alpha). Moderate item-to-item correlations were found (.34 to .58), suggesting good independence of items. However, a series of factor analyses were conducted and the result was a two-factor solution having 7 items (the RAQ-7). This solution was retained for parsimony. The two factors tap dimensions related to the fact that recovery requires faith and secondly that the paths to recovery are varied. The internal consistency of the two subscales and the total score were, respectively: .66, .64 and .70. Test re-test reliability with another sample of 85 individuals provided evidence of stability of the scale, with a .67 coefficient for an average of 19 days between administrations. Known groups validity suggested, as might be expected, a significant difference among the respondent groups in their attitudes toward recovery, with mental health professionals having the most positive attitudes. Concurrent validity was suggested by analyses indicating that suggesting more positive attitudes among those who stated they were in recovery (Borkin et al., 2000).

The Tennessee Self-Concept Scale (TSCS). The Tennessee Self-Concept Scale (Fitts & Warren, 1996) is a widely used self-report measure consisting of six self-concept scales (physical, moral, personal, family, social and academic/work) that yield a total summary score for total self-concept and conflict. Respondents are asked to report how true each statement is about them using a five-point scale ranging from Completely False to Completely True. Negatively worded items are reverse scored. A summed score for a subscale between 40 and 60 is considered within normal limits, while scores above 70 and below 30 are considered outside of the desirable range.

A fairly substantial revision was undertaken with the TSCS recently so that some items were eliminated and some added. Over the period of this study, both the older and the newer version of the scale were used, preventing a more complete analysis of the data. We cross-walked the old version of the scale onto the new version and were

able to analyze the primary subscales, less the academic scale. We were also unable to compute a total score without substantial imputation of missing data (any respondent missing more than 25% of the items was excluded from the analyses).

The Personal Vision of Recovery Questionnaire. The Personal Vision of Recovery Questionnaire is a 24-item self-report measure of recovery beliefs (Ensfield, 1998; Ensfield, Steffen, & Borkin, 1999). It was developed with mental health consumers and tested with 261 service recipients with self-reported psychiatric diagnoses. Five key factors that reflect the multi-dimensional nature of recovery beliefs were identified: a) Support, b) Personal Challenges, c) Professional Assistance, d) Action and Help-seeking and e) Affirmation. These five factors were identified by the scale developers as being important in the process of recovery. Similar to the RAQ, the 24 items are measured on a five-point scale from Strongly Agree to Strongly Disagree. The measure appears to have adequate psychometric properties (Ensfield, 1998; Ensfield et al., 1999).

Results

We examined the outcomes of the standardized training intervention on individual trainees' pre to post vocational outcomes and their gains in terms of subjective measures. Analyses to examine pre-to-post changes were conducted with paired *t*-tests for correlated data. Alpha level of 0.05 or below was considered statistically significant. We provide the results of those tests along with the confidence intervals for the difference between the pre and post means when they achieved statistical significance. Effect sizes were also calculated as Cohen's d, using means and standard deviations from the pre and post test means. In order to obtain a more conservative estimate of effect sizes, Cohen's *d* was not adjusted for the correlation between pre and post test results.

Vocational Outcomes

All participants acquired skills to criterion and graduated from the program. All graduates obtained mental health positions, and 89 percent were still working 12 months after they were hired. Twenty-nine percent of the jobs obtained were full-time positions; 52 percent were part-time positions and 19 percent were hourly. The average starting hourly wage was $9.33/hr and full-time salaries ranged between $23,566 and $40,000 and included comprehensive benefits.

Subjective Outcomes

Table 2 presents a summary of the pre to post evaluation for total scores of the subjective measures. Results of the analyses of the total Empowerment Scale suggested statistically significant and positive changes from pre to post test. The effect size was calculated to be 0.52. The pre to post difference indicated that the participants reported feeling more empowered after the training than before the training.

Changes in the total Recovery Attitude Questionnaire also reached statistical significance with an effect size of .40. The effect size for RAQ subscale one score (example item: "To recover requires faith") was calculated to be 0.37. The effect size for RAQ subscale two (example item: "People differ in the way they recovery from a mental illness") effect size was calculated to be 0.28. The difference between pre and post test for subscale two was not statistically significant but did indicate a trend in the desired direction.

In contrast to the positive change scores on the Empowerment Scale and RAQ total and subscale scores, the mean overall PVRQ score at baseline was 2.08 ± 0.33 (in the range of "Agree") and at endpoint was 2.10 ± 0.28. The effect size was calculated to be 0.06. This difference was not statis-

Table 2—Results of Pre to Post Subjective Outcomes Achieving Significance

Total Subjective Outcome Measures	Pre Mean (*SD*)	Post Mean (*SD*)	*CI*	Paired Value	*P*
Empowerment Scale (Total Scale)	2.77 (.30)	3.13 (.32)	(-.22, -.09)	4.77	.0001[b]
Recovery Attitudes (Total Scale)	1.71 (.42)	1.55 (.37)[a]	(0.05, -0.27)	2.87	.006[b]
Factor One	1.73 (.53)	1.55 (.45)	(0.04, 0.31)	2.67	0.010[b]
Factor Two	1.68 (.48)	1.55 (.46)	(-0.004, 0.27)	1.93	0.058
Tennessee Self-Concept Scale (Personal Sub-Scale)	43.38 (6.74)	45.00 (6.69)	(0.42, -2.96)	2.66	.0098[b]

[a] Decline in scores represents a favorable change

[b] Denotes statistically significant change from pre to post test at $p < .05$

tically significant nor were changes in any of the subscale scores.

As also noted in Table 2, the difference between the pre and post-test scores of the Personal subscale of the Tennessee Self-Concept Scale reached statistical significance in the positive direction. The Personal subscale measures a sense of personal worth and includes items such as: "I am a nobody" and "I am a cheerful person." Changes in the other subscales (physical, social, moral and family) did not reach statistical significance (*p* values not shown).

Personal Narratives

In addition to a quantitative evaluation of pre- to posttraining changes, we obtained the personal stories of participants in order to document their experiences in the peer training.

My Story (Kasondra Flecher). One day I was talking to my voc rehab counselor and he said to me, "Have I got the job for you." "Peer Support Specialist," he says. I didn't really understand what he was saying, other than he thought I could do the job. Once in Peer Support Training, I learned that there were others just like me. We all were wondering if we could do "the" job, if work at all. It's an awful place to be; feeling at the mercy of your disability and dependent upon disability income. Personally, I couldn't stand the helplessness any longer. I longed to be a bona fide citizen again. Peer Support Training was the best thing that ever happened to me. I got offered a great job that put me at a desk and gave me a sense of direction in my life. I even found the courage to look up my family—I hadn't seen them in 20 years. Right after graduation, I was on a plane trip to see my Dad. Seeing my family has been ongoing since. Today, my sister lives only a few miles down the road from me. She moved from Texas after hearing my story. Today, it's almost 2 years since I got into Peer Support Training. I still have symptoms. I still take medication. But, I also have a job I'm proud of. And I'm proud of me. I have succeeded in things that I was beginning to lose hope for. I have my family back. Better yet, I have my life back. (Authors' note: This person was hired 1 month after graduation from the Peer Support Training Program in a full-time position at $11.83 an hour; since then she has transferred to another full-time position making $13.50 an hour.)

A Story of Success (Michelle Krasinski). I am a failure. That statement is what I believed to be true my entire life. After surviving many traumas and being labeled as a mental patient, I lived with no expectations of myself except to fail. And that is what I did. Or at least that is the way I felt. I set myself up to fail every endeavor I challenged myself to. I tried many jobs and would be okay for a few months and something would happen. A major crisis, an illness, a trip to the dentist, drug addiction, a move across the country, all events that gave me permission to hang onto being sick; therefore I will not succeed. Finally I got sick of being sick and gave in to the idea of a vocational rehabilitation counselor. I committed to 5 weeks of peer support training and to develop a WRAP plan. My thoughts were I have nothing to lose and maybe I'll find a job that I can be sick at and it will be okay. I was SO wrong! I was able to find a job that being "sick" was an experience that I could share and recover from and leave in the past all at the same time. It was time for me to begin to grow. I learned that I have value. I have been committed to helping others by sharing my life experiences. I am also still learning something new every day from my peers. I learn from my own experiences. What I once would have considered a mistake or a major crisis I see as a lesson. I had the confidence to step out into the world on my own. My personal growth has enabled me to work as a committed employee, a feat I had not been able to accomplish before because I lacked self-confidence, motivation and a basic desire to live. I am finally independent, financially and emotionally. Yes, I do need support but I am not dependent on anybody but myself to meet my needs. The person that I was meant to be finally has been granted permission to emerge. I like that person! (Authors' note: This person started working part-time at $8.82 an hour. Five months later she was promoted to a full-time position at $30,000 per year.)

Discussion

The purpose of this study was to determine the personal and vocational impact of a peer support training intervention on individuals with serious psychiatric disabilities. We found that the standardized peer support training program was successful in increasing participants' knowledge and attitudes toward recovery and their sense of empowerment. We also observed gains in the personal subscale of the Tennessee Self-Concept Scale, which measures a sense of personal self-worth. Examination of effect sizes suggests moderate changes before and after training. These data suggest that peers experience positive changes on these subjective psychological measures after participating in peer provider training.

As far as we could ascertain, this is one of the only evaluations to test a structured and formal peer support training program. Few mental health or peer-run programs appear to rely on standardized or tested peer training models (Clay et al., 2005). For the most part, even peer-run programs that appear to be "best practices" rely on more informal training and support for their peer providers. The exception may be peer programs whose primary

approach is educational, such as the Advocacy Unlimited Program in Connecticut, which trains peer advocates (Sangster, 2005) or the Bridges program, which is highly structured (Hix, 2005).

Furthermore, in addition to psychological changes, vocational benefits accrued to the recipients of peer provider training. Only 11 of the trainees who agreed to participate in the evaluation did not complete the training program or advance to employment. Fifty-five of the 66 participants became employed at META Services, Inc. and the majority (80%) retained employment during the study period. The Peer Support Specialists were competitively employed as team members of the Home Recovery Team, an in-home crisis intervention service; as recovery educators facilitating WRAP and WELL (a skill training course in community living skills) classes; as crisis providers in a peer-operated crisis program; as coaches in supported housing programs; or as Peer Advocates in the county psychiatric hospital.

Recruiting, training and employing peer providers can assist the mental health field to embrace a more participatory model than the current model of minimal involvement that tends to be practiced (Chamberlain, 2005). Our experience in this study suggests that employing peer providers within the mental health system is a strategy that can promote not only needed transformation within the mental health system, but, we expect, will also promote positive changes in the individuals trained. Employment of trained peer providers is a way of indicating to the individual that their experiences as consumers are valued by the mental health system. This dual role can be a positive force in the experience of recovery and citizenship of the individual as well as to the integrity of the mental health system.

However, training and employing former mental health recipients as providers of services presents certain challenges to the existing structure and design of mental health service delivery, in essence, a paradigm shift. META determined that integrating Peer Specialists into their workforce required an organizational transformation in order to embrace peer providers as valued members of the team of providers. Thus, agency-wide training in the principles and practices underlying recovery in an effort to promote this shift is provided for all staff. Natural on-the-job supports and coaching for peer providers is available on an ongoing basis. An examination and redefinition of the agency's human resource policies and statement of ethics and boundaries was necessary to promote this shift. Language, documentation, and service planning have all became more respectful and person-centered. All of these steps were needed to ensure success of the peer provider model.

The current study has several limitations, most critical being the non-randomized nature of this evaluation. This one group, pre-post-program evaluation, has threats to internal validity. The lack of a control group to whom the gains could be compared is the primary limitation, thus making it difficult to know whether non-trained individuals would experience similar gains. Replication of this intervention within the context of a more rigorous and controlled study will allow us to make more definite statements about its effectiveness.

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