

A Qualitative Field-Based Study of Peer Specialist and Paraprofessional
Work and Relationships With ICMs and Clients

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1. Introduction

This study is the second part of a three part qualitative evaluation of the Peer Specialist Program, focusing on the context and the nature of the work of peer specialist and paraprofessional counselors. In addition, the study considers the relationships between counselors, ICMs and clients as they became apparent during a six month period of field observation during the third year of the project. In contrast to the formative evaluation study which relied primarily upon key interviews with project staff, this study utilized participant-observation and informal interviews in a range of settings: in visits with clients at their apartments or residences, in the streets and subways, at the hospital and other professional settings.

This field study was designed to investigate the actual roles and relationships and work activities of the two project staffs as hypothesized in the grant application. These postulated that peer specialists and paraprofessionals would develop unique and different strategies of working with clients and their Intensive Case Managers. Peer specialists were expected to implement their experiential knowledge of the mental health system in their work with clients, while paraprofessionals were expected to contribute their knowledge of local community resources and neighborhoods.

2. Methodology and Study Design

In order to assess the nature and impacts of peer specialist and paraprofessional ("counselors") relationships to and work with clients, the qualitative researcher, over the course of six months, accompanied

counselors and their ICMs on visits to clients. In addition to accompanying counselors or counselor-ICM teams in the field, the qualitative researcher also spent time with counselors in the office at the hospital, attending meetings, participating in informal discussions of clients and work, and observing the content and patterns of the counselors' office and field work.

The original study design designated that the qualitative researcher accompany each of the seven counselors for two weeks each, in order to observe interactions of counselors with ICMs, clients and each other. The goal of this original design was to develop a catalogue of activities and descriptions of counselor-ICM-client relationships.

Several problems were encountered in implementing the established field study design. For one, the plan to follow each counselor over a two week period proved both difficult and inadequate. In some cases, numerous visits yielded few contacts with clients. This occurred for several reasons. Because few clients could afford to maintain working telephones, counselors had to establish fairly regular times of the day and the week to visit clients. Some clients enjoyed a variety of social contacts outside of their rehabilitation programs, and thus were not readily available when counselors tried to "drop by."

In addition, the vagaries of public transportation often frustrated the arrangements made between counselors and clients. It should be noted that either counselors or clients followed up nearly every missed appointment with a visit or phone call. In some instances, clients even came to the hospital to visit the peer specialists' office after learning from family or neighbors that the counselors had been trying to reach them.

The fact that none of the counselors had independent access to state ICM cars meant that an entire day could be spent tracking down a single client

or family member, or accomplishing a single visit with a client to a clinic or other appointment. Once counselors had arrived at the appropriate subway or bus stop, any distance from several blocks to half a mile was regularly covered by foot to the client's doorstep. In the entire duration of the field study, only two apartment building elevators were in working order, further necessitating the counselors to hike numerous flights of stairs. These conditions were best appreciated by the two counselors who worked through their eighth months of pregnancy during the field study. Thus the amount of time spent using public transportation and walking to clients' apartments or residences also increased the amount of research hours spent in order to meet clients. These various conditions posed the necessity of extending the field study by several weeks.

In addition to the difficulties encountered with transportation, the reluctance of two counselors to be "studied" required an extension of the field study after numerous cancelations or evasions of appointments with the qualitative evaluator. Rather than taking a confrontational approach, the qualitative evaluator proceeded to accompany other counselors on their visits, and accompanied the other two counselors less systematically, that is to say, when their convenience and the researcher's coincided. Eventually all counselors were studied for a minimum of two weeks each, and nearly all of their clients visited by the qualitative researcher.

An additional reason to extend the duration of the field study was raised by one of the peer specialists who insisted on a "fair", rather than "random", representation of his work and his clients. Arguing that each client is an individual, the peer specialist insisted that I meet each of his clients. Also noting that the mood and situation of each client differs from day to day, the peer specialist insisted that merely meeting each client once

would skew perceptions of clients. This advice proved true, and the qualitative research has benefited from an extended investigation into client and counselor relationships.

As with much participation-observation research, the rhythms and pace of counselors' work and client relations eventually became mirrored in the work conditions and experiences of the qualitative researcher, thus validating oral accounts of counselors' work concerns and descriptions of clients. The peer specialist office doubled as an office space for the qualitative researcher, who would utilize the desk tops of whichever counselors were out in the field at the time. While this proved a difficult environment for writing fieldnotes and reports, it was an ideal situation for the qualitative researcher to get to know ICM clients and observe interactions between clients and counselors.

This approach has also made it possible to learn the patterns of counselor responses to client contacts, as the qualitative researcher participated in "next day" office conversations about visits with clients, their progress, the experiences which moved or concerned the counselors, and the counselors' follow-up communications with ICMs. Finally, these changes in initial study design facilitated longstanding relationships with clients, some of whom eventually participated in the social club organized by the peer specialists and generously allowed the participation of the qualitative evaluator in social club activities.

3. Work Environment and Work Relationships

a. In the Office

Peer specialists and paraprofessionals shared a large office which was a former day room in a hospital ward now used exclusively as office space. This arrangement, based on practical considerations, created significant and unanticipated consequences within the project itself and the evaluation research. Hypothesizing that each group would contribute according to members' distinct background, this office arrangement fostered a considerably greater amount of shared relationships and interactions among project staff than was anticipated. Whether this in fact led to a substantial contamination of the respective interventions remains unclear. However, the qualitative findings indicate that these interactions highlighted differences between the two groups' experiences. In spite of certain irreducible differences based on mental health experiences, peer specialists and paraprofessionals developed strong ties to each other which lasted throughout the project.

Counselors usually came "to the office" in the morning to check in with ICMs to see if they needed any "help" in the field, or ascertain which clients' ICMs planned to visit, and thus establish which clients counselors might visit that day. Over the course of this field study, it became apparent that the morning check-in served several purposes. While it overtly provided the point of coordination between counselors and ICMs, it also became a point of departure as peers and paras increasingly reported their own client appointment schedules to ICMs, who then would schedule time later in the week for the counselors to accompany them on client visits. In other words, peer specialist and paraprofessional schedules and interests in clients increasingly took priority over the requests and needs of ICMs.

It is significant that the majority of counselors "checked in" by telephoning the ICMs whose offices were just one floor above the peer and paras office. While one individual made regular morning appearances to the "ICM ward upstairs," others found this method of checking in to be a reminder of the perceived lower status of peer specialists and paraprofessionals in comparison to ICMs. "If they really want to see me, they can come down here and see me" was an oft-heard remark by project participants who had grown tired of running the flight of stairs between the two offices.

An office space famous for having the coldest and cleanest water in the entire building, the peer specialists' office attracted more hospital staff than ICMs, and more ICM clients than hospital staff. Seeing an ICM in the peer and para's office usually meant "something is up," the most common issues being an ICM's exasperation with a client ("You call her!") or an ICM taking issue with a peer or para who had taken independent initiative with an ICM client. One ICM confided to the peer specialists that their office used to house the desks of several ICMs, and now acted as a reminder of ICMs potential displacement by other kinds of social workers such as peer specialists or paraprofessionals. (Some of those ICMs who "lost out" in the ICM office space lottery use the Albert Einstein library facilities many blocks down the road to do paperwork.) Thus the feeling that, through the assignment of office space to the peer specialists and paraprofessionals, ICMs had been denied badly needed space in the hospital, established an unspoken tension between "the fifth floor" and "the sixth."

Known by ICM clients for its sofa (secured from the trash by one of the paraprofessionals), its coffee machine, and its friendly atmosphere, the peer specialist office became a social center for clients. The office became a place for

them to check in with peers and paras about ICM-related issues, to say hello, to rest and relax, to get information on activities, and to discuss problems--- even seeking support in order to keep going when all seemed impossible. The peer specialists started a used clothing closet in the office, of which ICM clients, hospital staff and project staff happily took advantage.

The peer specialist office itself mapped out certain distinctions within the project, spatial divisions which the peers and paras said they did not note at the time they set up their office. Peer specialist desks were placed in a tight configuration near the office entrance, in such a way that all three desks touched. In the peer specialist space, a used clothing rack with items donated by project staff, hospital staff and clients drew the interest of ICM clients. Marking the zone of shared space, the project's wall calendar, bulletin board, refrigerator, coffee machine, and the famous water fountain were set opposite the supply shelf. Behind the large metal supply shelf, paraprofessionals' desks were situated singly along both walls. One peer specialist's desk is situated in this area, but faced the peer rather than the paraprofessional desks. Set against the back wall in paraprofessional space sat the sofa which welcomed both groups' clients and provided the social backbone of most staff meetings. Thus although the office space was shared, the counselors organized distinct sections for peer specialists and paraprofessionals.

The use of various office areas also made apparent the social divisions between the counselors, ICMs, and other project professionals. Project professionals with offices in other buildings were sometimes referred to by the counselors as "the adults," who would visit "the kids" in the Thompson building, or who would "call the kids over for a meeting with the adults." Management meetings always took place in the Administration Building, and ICM-related meetings occurred in the ICM conference room on "the ICM

ward." Numerous spontaneous problem-solving and scheduled meetings occurred among peer and paras in the office. The project facilitator held peer specialist and paraprofessional staff meetings in their office. In addition, discussions between project and other consumer advocates took place in the peer and para's office, and social club meetings often originated in the peer specialists' office.

"Being on the phone" was taken to be the most professional type of activity in the office. Because few ICM clients have telephones, peers and paras spent "phone time" contacting agencies and clinics in their advocacy work for clients. Setting up appointments for clients often took a number of contacts to finalize, requiring calls to ICMs, calls and/or visits to clients, calls to clinics or other offices, and follow-up calls the day of the appointment.

3b. In The Field

Counselors commonly distinguished between work that occurred "in the office" and "in the field." Whereas work in the office occurred within certain divisions of space and means of communication, work in the field was largely conditioned by the means of transportation used to visit clients. The symbolic importance of the ICM "state cars" was driven home at one New York City conference at which ICMs presented a slide show about their case management work. One ICM presenter asked the audience, "Where would an ICM be without his car? Stranded, that's where."

Although all counselors agreed that taking public transportation was the most frustrating aspect of the job, all regularly took public transportation in order to visit clients independent of the ICMs. This preference developed through a range of experiences in "going out with the ICMs." Peer specialists

particularly disliked arriving with ICMs at the clients' residence, and peer specialists felt the partnership approach hindered the independent establishment of trust between client and peer. In response to certain tensions that had developed between counselors and ICMs (c.f. the "Mod Squad" initial evaluation report), peer specialists particularly preferred to see clients independently from ICMs. This choice was facilitated by using public transportation in spite of its own disadvantages.

Peer specialists and paraprofessionals also insisted upon independent travel for positive reasons. Both groups felt that taking public transportation, while tedious and time-consuming, familiarized them with clients' neighborhoods and neighbors. Peer specialists and paraprofessionals also acknowledged the dangers implied by taking public transportation and the validity of the fears which encased ICMs in their state cars.

Traveling by foot to meet clients, rather than taking public transportation, constituted the greatest danger in the field. "You walk like you know where you're going," one peer specialist commented as we walked to visit a client. "The ICMs walk like they've never been in the Bronx before." When walking, one has to be especially alert and responsive.

(A paraprofessional and I) walked the back trails to the Middletown Road Station, where a carful of white teenaged men tried to hit us as we crossed the intersection with the light. I grabbed S's elbow and we ran as they swerved to run us over, shouting "nigger" and "bitches" at us. We got across the road, sat down on the subway stairs where she said,

"Did you hear what they said? That was about prejudice as sure as I'm alive. Niggers? Bitches?" She said this had happened to her once before while visiting a client...We were both incredibly shaken, and the fact that she was pregnant wasn't lost on us either, as we realized we could've been hit or could've fallen while running. She said she always has to watch herself when out on the street. That you never know when people will "direct their hatred at you."

Thus the conditions of peer specialist and paraprofessional work were not only established through the attitudes of ICMs and other professionals, but through attitudes and other conditions operant in the city.

In the eyes of peer specialists and paraprofessionals, the discomfort most ICMs felt in the field implied a discomfort with individuals for whom "the field" is home---namely clients and the counselors. This discomfort was most often expressed through a nervous sense of humor, evidenced by one ICM singing the theme song to Mr. Roger's Neighborhood on the way to see a client. "It's a beautiful day in the neighborhood; a violent day in the neighborhood. Won't you be, won't you be, please won't you be my mugger?" For peer specialists and paraprofessionals who live in or near these neighborhoods, humor about violence was not so readily available.

As we walk to a client's apartment, we cross over a sludge-slow stream and pass by at least five burned-out buildings. Chain link fences

separate us from lots with tall grass growing in clumps around all types of garbage, debris, rusted car parts, empty barrels, broken boards, piles of broken slabs of cement, the occasional kid's bike tossed on the heap. Empty crack vials are jammed into the cracks in the sidewalk. I ask the paraprofessional whether their neighborhood is anything like this one. "Yeah, it's as bad; people getting shot every week; people doing crack in the park."

At the same time, counselors noted the diversity of living conditions in the Bronx and took pride in the "community spirit" of their own various neighborhoods, and publicly countered stereotypes of the Bronx proffered at conferences and other events.

Thus counselors found their community-based work challenging in its own right. To visit clients in the South Bronx, one peer specialist utilized every possible bus route. While taking the bus was more time consuming than he liked, he noted that "the scenic route" afforded him a "focus in my mind that I can then share with the clients. Otherwise I'm using it all up on myself." Perhaps the main difference between ICM and project counselor attitudes is that the latter worry about the ways in which "the field" is dangerous for clients and not just for themselves.

4. Work Practices

a. "Following the Research"

Both peer specialists and paraprofessionals---and, to an extent, ICMs---were expected to follow certain basic stipulations outlined in the original grant proposal. For example, ICMs were assigned to work with either peer specialists or paraprofessionals; thus ICMs worked only with project staff from their ICM team's assigned group. In addition, peer specialists and paraprofessionals could only work with clients assigned to their teams' ICMs. Research considerations structured initial negotiations over peer specialist and paraprofessional roles in the field, and grant hypotheses were cited when paraprofessionals voiced an interest in, but were denied permission to help organize and participate in the social club. Continually peer specialists and paraprofessionals reminded each other that "that's not in the research," when various counselors came up with creative collaborative ideas for working with clients or with each other.

By giving peer specialists the self-help and empowerment mandate, the internal and management team implementation of research design in part gave peer specialists a freer reign to work creatively with clients. Provided with the encouragement and funds to develop their own approaches to self-help and empowering relations with clients, peer specialists truly experienced themselves as pioneers in a formative field.

Yet their placement in the "peer specialist" category was also experienced as constraining. Peer specialists did not always consider their mental health experiences as central to their identity, and felt obligated to underplay other types of potential peer relationships within the project--such as those based on shared interests, similar age, gender, or ethnic identity, or

living in the Bronx. Paraprofessionals also experienced their group assignment as constraining. Accepting self-help and empowerment approaches as "simple common sense," "the best thing for clients and for society," and not only as artifacts of mental health experiences, paraprofessionals felt they were assigned to a "quieter" category. "They work in the spotlight, promoting these new techniques. But we have ideas, too."

After months of being reminded what was and wasn't allowed by "the research," both groups settled into a certain acceptance of a categorical (peer specialist vs. paraprofessional) approach to individual work. Even so, individuals within each group differed in their approaches and focuses with clients. Thus the research design did not ultimately determine peer specialist and paraprofessional work practices or client interactions, but did establish certain clear boundaries and tensions which maintained the integrity of experimental (peer specialist) and control (paraprofessional) groups established for quantitative analysis.

When asked if they were given the chance, paraprofessionals agreed they would have welcomed the opportunity to take on a more advocacy-oriented role with clients. Paraprofessionals tried to advocate for clients to the best of their ability within the confines of the research design and the ways the management team, the ICMs, and the ICM coordinators interpreted and enforced "the research," just as peer specialists tried to live up to the potential which the grant hypotheses outlined for their roles. The counselors found their participation in the qualitative research to be an arena to reflect on "research differences" in contrast to the counselors' various and distinct qualities as individuals who "grew by leaps and bounds" while on the project.

4b. Differences Between Counselor Work Practices

In order to ascertain differences between peer specialist and paraprofessional work practices, the qualitative researcher developed the following lists of activities based on findings from participant-observation. In compiling an initial list of work practices for each group, it became apparent that both groups organized their work independently, with ICMs, and with other project staff. In addition, important differences in the range of work practices and level of independence of the two counselor groups emerged.

4c. Table 1: Catalogue of Work Practices

Peer Specialists

Independently:

- accompany clients to entitlements and psychiatric appointments when there has been some difficulty securing services for the client
- accompany clients to medical appointments when the client is experiencing a major medical problem
- coach clients on how to better work with ICMs
- visit clients when client or peer identifies an oncoming crisis
- visit clients who have been hospitalized; assist them with needs
- accompany clients to court appearances
- listen to clients when they want to discuss their lives
- help clients relate the needs in their lives to either securing social services or developing self-help approaches
- follow up with ongoing conversations, questions about how things are going with entitlements and personal life
- encourage clients who refuse or cannot secure certain services (e.g. drug rehab) to create their own personal (i.e. non-service-systems oriented) solutions, practices, or plans
- make available monies for "leisure activities"
- accompany clients to movies, museums, restaurants/diners
- utilize the time spent in leisure activity to establish peer relationships and the basis for further advocacy work with clients.
- talk with clients about their daily lives, their own perspectives, and their dreams.

- encourage clients to think about themselves beyond the categories of mental health or social work fields
- attend ongoing (monthly) ICM alumni training sessions at Hunter College
- organize and participate in PEERS club activities

With ICMs:

- visit clients that the ICM feels would benefit from peer contact
- clarify the nature of client rights
- communicate problems in service delivery from the client's perspective, including the effects of professional attitudes towards clients
- negotiate case management approaches to clients in one-on-one and team/unit meetings
- discuss (and, when necessary, defend) the integrity of peers' experiences as consumers/survivors
- recordkeeping after the first two years of the project (cf. section 4f below)

For ICM Project:

- answer ICM switchboard when ICM secretary is out of the office and no replacement has been secured
- represent ICM project by speaking at professional events

With other project staff:

- attend local, regional, state and national conferences
- attend monthly project management meetings
- participate in qualitative evaluation research

Paraprofessionals

Independently:

- take clients to entitlements and medical appointments
- visit clients to pass messages on to them from their ICMs
- coach clients on how to better work with agency social workers and doctors
- listen to clients' concerns during travel time to appointments or at the end of home visits
- write daily logs, progress notes, monthly reports, and client chart information

With ICMs:

- accompany clients to medical appointments, medication appts, and (actual or anticipated) psychiatric hospitalizations

- assist ICMs in locating clients in "difficult" neighborhoods
- accompany ICMs in visiting "difficult" clients
- attend unit and team meetings

With other project staff:

- attend monthly project management meetings
- participate in qualitative evaluation research

Clearly the peer specialists participated in a wider range of interactions with clients, ICMs, project staff, and other mental health professionals. Because of peer specialist and paraprofessionals' differing relationships to ICMs (which were set up in part through the original grant proposal as well as through extensive role negotiations in the first year of the project), peer specialists and paraprofessionals sometimes performed the same tasks or participated in similar interactions with clients, but under different auspices. In other respects, the two groups performed distinctly different tasks which facilitated distinctly different relationships to clients and ICMs.

While it appears that peer specialists may have performed twice as much work as the paraprofessionals, this is not the case. Paraprofessionals worked within a narrower range of activities, performing these on a regular and frequent basis in their work with clients and ICMs. Paraprofessionals worked with an equal, if not greater number of clients. Both groups of counselors spent similar amounts and proportion of time in the office and in the field.

Involvement in recordkeeping and participation in client crises proved significant in establishing the counselors' level of professional status or acceptance in the eyes of the ICMs. However, two factors primarily contributed to structuring the differences between peer specialist and paraprofessional work with ICMs and clients in the office and in the field: 1) the peer specialists' collective and conscious decision to prioritize the needs of

the ICM clients over the needs of the ICM program and individual ICMs, and
2) the implementation of the original terms of the peer specialist research
demonstration grant.

4d. The Provision of Peer Counseling

As described in the initial evaluation report, it took a while for the
unique contributions of peer specialists to emerge while the project was being
implemented. Independent relationships with clients had to be achieved in
order to enable the practice of peer counseling to occur. These were
established in various ways. At first, ICMs introduced peer specialists to
clients in their new case load. Several peer specialists described an initial
process by which some ICMs over time authorized peer specialists to work
with clients independently. The following account depicts this process.

The ICM dictates who you can work with, and when.
I noticed several things from the start, that I wanted
to do for the client. There was poor ventilation in
the apartment, the kitchen needed cleaning, and the
client's hair was too long, he needed a shave. There
was laundry piled to the ceiling, and you know how
depressing a huge pile of laundry can make you.

The peer specialist brought these things to the ICM's attention, but the ICM
indicated it wasn't time for the peer specialist to start working with this client
yet.

The ICM said it would take months for me to develop a rapport with the client, because the client was an especially unfriendly character, unshaven, sloppy-looking, and a dirty apartment. Finally, the ICM got disgusted with how the client looked, and called him up. The ICM goes, 'I'm sending someone over to help clean you up.' Now that's hardly how I wanted to be introduced!

As the peer specialist in the above passage noted, "It was almost like the ICM had to reject the client before he could let me work with the client on my own. That's a pity because it has nothing to do with the client at all."

After the client had been assigned to the peer specialist, ICMs tended to leave peer specialists alone to handle most issues. Examples of autonomous work included court appearances, meetings with physicians over health complications, advocating for client access to medical treatments and educational programs open to the public. Once peer specialists had begun to work independently, ICMs only invited them to visit clients when they wanted to share a curious or problematic development. Peer specialists wondered whether this was a way for ICMs to seek their opinions on clients without stating so explicitly.

A number of challenges to peer relationships emerged once peer specialists began sharing their own hospitalization and recovery experiences with clients. Introducing such information did not immediately establish peer relationships between clients and peer specialists. Peer specialists confronted their own confusion about the appropriate uses of their own stories, the contexts in which to reveal personal information, and the

unknown effects these testimonies might have on clients. In addition, peer specialists felt that the advice and guidelines offered by professionals "psychologized" rather than clarified the nature of such confusions.

The principles of peer counseling (cf. appendix) developed and formalized by the first project facilitator proved helpful in outlining practical and ethical considerations for peer counseling relationships. The ongoing modifications and additional guidelines established by the second project facilitator further clarified how to negotiate differences between peer specialists and clients (as well as the intervention of professionals into peer relationships), and provided a framework for sustaining long-term peer relations of mutual benefit. Both facilitators emphasized the importance of recognizing that peer specialists and clients have similar and different experiences in life and within the mental health system, are individuals in their own right, and therefore make similar and different contributions to the peer relationship.

Because the second facilitator had direct access to clients through her initial work as peer specialist, peer specialists were eventually able to develop their peer relationships with clients by working with the specificities of each client's situation. In other words, principles of peer counseling were used as guidelines to help peer specialists get to know the specific needs and hopes of clients, and attend to those over time. Advice was not the goal of peer counseling as implemented by the peer specialists. Rather peer specialists sought to establish working relationships with clients, enhance client and their own empowerment, and sustain relations of mutual help between peer specialists, clients, and individuals close to the client. As the second project facilitator stated,

Peer counseling is about process and relationships. What you go through separately and together, and where that takes you. You can structure that, but structure isn't the goal. Structure is too much about control. You want to learn how to get through something separately and together, and it has to be real.

Making peer relationships "real" meant that peer specialists didn't "just talk" with clients; they "did things" with clients, and they learned what clients wanted peer specialists to do for them. This integration of peer counseling within the context of providing other services became an important organizing feature of peer counseling within the peer specialist project. The following examples demonstrate this powerful approach to peer counseling and service provision in general, and show how this approach allowed for the translation of empowerment and self-help standards into individualized approaches to peer counseling.

Peer specialists integrated peer counseling with the provision of numerous other services, often in a very sophisticated way. The following example shows how a peer specialist, working with a client who had been hospitalized for a medical condition, provided individualized services as a way to develop rapport with a client. As evidenced below, the emergence of peer relationships over time---according to the client's sense of time, not the provider's---played an important role in the provision of peer counseling.

At the hospital, (the peer specialist) spent nearly three hours at the client's bedside, giving him a "serious haircut" and a shave. At each point, decisions

for the client to make, choices. Does he like his hair combed up or down? Long sides or short? A really close cut, or long in the back? 'How about the moustache, should we trim it?' 'Yeah, man, trim it so it looks cool.' Occasionally the peer and client ask my opinion on style, 'so it looks cool to chicks.' This haircut is quite the occasion, lots of chatter as the peer took off layer after layer; a chance for the peer to ask questions in a neighborly way, not in a case management way, couched in this comfortable contact. The peer really didn't need to go so slowly and carefully with the haircut; he didn't need to crank the client's bed to get him comfortable and sitting at just the right height and angle for a haircut. But as the peer specialist said in a meeting with the director of BPC a few days later, 'there's nobody in the Bronx who's gonna take the time to give cool haircuts and shaves to ICM clients--just me. You could say that's my specialty.'

Because of the different ways each peer specialist integrated their own individual experiences and skills in the provision of peer counseling, professionals had difficulty understanding and accepting this unique kind of "client-staff" relationship. This was exemplified in professionals' assertions that peer specialists provided a vague "empathy" or were "just being there" for ICM clients. On some occasions, the detailed descriptions peer specialists gave of their services and relationships to clients generated subdued laughter

on the part of professionals or heated debates over whether such services could be funded under the classification "leisure services" or "program enhancement."

It is significant that peer specialists did not, on the whole, assist ICMs in hospitalizing clients of enforcing medication compliance. Because peer specialists were not called upon to participate in what paraprofessionals experienced as "foreceful and sometimes very sad" interactions with clients, trust could develop and the status of "peer" could remain intact between peer specialists and clients. Rather than hospitalize clients or enforce medication compliance, peer specialists visited clients while hospitalized and as a way to prevent hospitalization. Although peer specialists would speak to clients about their medications, oftentimes at the request of clients, information about medication compliance was not always reported back to the ICMs.

Peer specialists intervened in other kinds of crises with clients. They accompanied ICM clients to appointments with medical doctors when clients experienced major medical problems, as wel as to follow-ups in order to provide support and advocacy when clients returned for test results or final diagnoses. All of the peer specialists assisted clients in advocating for services or benefits to which the client was entitled but had been denied.

In fact, peer specialists offered peer counseling within the context of assisting clients with "concrete services:" securing entitlements benefits, offering food or clothing, providing necessary information for clients to take action in the mental health, legal or medical systems, or addressing other immediate financial and social needs. Peer specialists insisted that "the therapy model of self-help that focuses on talking about problems" is inadequate for clients strapped with significant material needs in their families and neighborhoods. Peer specialists acknowledged that there are few

services in the Bronx mental health system---if in any mental health system in this country---that work with the dreams and desires of mental health clients.

Peer specialists worked most closely with these aspects of the clients' lives, in ways that made relating desires and goals seem a possibility. Rather than fit clients into the categories of mental health services, the peer specialists allowed clients to develop "non-mental health" aspects of their lives in ways that surprised both parties.

Peer specialist attitudes toward clients were marked by a belief in people's recuperative abilities and the power of that belief as evidenced through the peer specialist's own experiences of recovery. However, peer specialists, using great sensitivity and individual criteria, decided upon the appropriate use or disclosure of their own mental health experiences on a client-by-client and situation-by-situation basis. In the above example, the peer specialist offered very little discussion of their experiences in the mental health system, because (as the peer specialist explained) "the client was significantly older, and to use myself as an example to an elderly individual would prove very disrespectful."

In another situation with a client, one peer specialist decided not to disclose to a client who had been attacked that at one time they had a similar experience. "It is very personal, how people understand some traumas in life, and it was best for the client to use their own experience as the standard, not mine. Plus getting so personal would have been hard for both of us." Thus in the peer specialist program, self-disclosure was not always seen as the "key" to peer counseling. Rather, a sensitivity to and respect for themselves and clients guided the provision of peer counseling

On the subway a peer specialist read me the Thanks a Million column in the Daily News, a column written by a millionaire who considers the requests of various "cases" for funds. This week featured an abused teen with a family member diagnosed as schizophrenic, and unable to hold down a "regular job." The millionaire columnist sent the teenager money for nice clothes that she asked him for, with the comment that "it's a real tragedy when somebody can't work." The peer said they weren't sure if it was a "tragedy;" that they saw ongoing suffering from mental illness, in spite of the desire to get better, as the real tragedy. "Then call the rest a mix of unemployment and prejudice and deal with that."

We were going to visit this peer's star client, an individual who used to land in the hospital every few weeks, until the peer specialist started visiting her. After they first "met," she went for almost a year without being hospitalized. At numerous meetings and conferences, the peer specialist has cited this client as evidence that peer counseling works. The client herself noted that since the peer has been "coming around," she's had numerous chances to go outside of her building and beyond her few nearby blocks, going to the movies or for lunch, and getting some "relief" from the familiar places where she usually smokes crack.

At her apartment, a resident greeted us, screening us with his eyes and gesturing us inside. A woman who arrived at the door at the same time was similarly screened and sent away. "That happens to the ICMs all the time," the peer advised me. I commented that the "doorman" looked high, and the peer was surprised that I know about crack. We climbed several flights of stairs, noting numerous violations of building codes, and didn't even have to knock on the client's apartment door. It was wide open, and from the hall, we could see several men smoking in the kitchen. We were let in by one

man, who immediately recognized the peer; "glad you stopped by." The man gave the peer a quick run-down on the client--his smoking partner--and her situation. He asked if the peer could be sure to go with her to pick up her check, because she's spending too much of it "on this stuff."

In the living room, the peer sat on the sofa, and I was given a chair near the kitchen. Doors hung halfway off the hinges, and the sofa and chair, along with a TV set and coffee table, were the only furniture in the entire apartment. "The bedroom is on the floor," the client pointed out to me. The peer asked the client how she's doing; she sat with the peer on the sofa. Three women in the living room chatted with me about the peer. They admired how often the peer visits, "always showing up at just the right times, somehow." The client confirmed that she took her medication today. He also asked her where she's spending Thanksgiving this year. "Here. Where else?"

The client asked him if he'd do her a favor, and keep \$50 for her, so she would have cash later to buy "a turkey and some extras." The peer agreed, but said, "what if you ask me for it back, to go out cracking?" She said that he'd have to honor her request, because it's her money. Two weeks later, three days before Thanksgiving, the peer made a special trip to give her the money back. Next day, the client spent it on crack. "I know it's the holiday coming up," she told the peer, "but what kind of thanks do I give for this (kind of life)? I gotta let out some real frustration." The peer confided to her that "I myself kicked that stuff one Thanksgiving, sitting in my apartment watching TV with friends. And haven't touched it since."

A month later, the client landed in the hospital. The peer noted that she had stopped taking her three different medications, had sold her apartment lease to a crack dealer who then "let" her stay there temporarily,

and that she refused to speak to the peer any more. Although the client's ICMs advised the peer not to visit the client any more, the peer continued to visit the client regularly, stopping by "to say hi" and get in a sentence or two before being kicked out of the building by the client. A number of factors could have established the client's refusal to work with someone who was previously their ally. However, when I asked the peer why keep going back to visit when you aren't wanted, the peer didn't try to analyze the reason for the change or moralize about the change in relationship. The peer said that's how they would treat any of their friends, that "you don't just dump people because they're in a crisis, or because they're not 'progressing.'"

When I ran into the client's ICM at a conference weeks later, the ICM explained that the peer wasn't at the conference, but was making a trip to visit this client. "He took the day off because he was worried about her. It's like his own sister getting sick." Days later, I accompanied the peer to visit the client, but she wasn't home. Outside the apartment, the peer recognized the client's brother hanging around, greeted him, and asked about his sister. "I think she went to get chicken." We walk for over a half hour, making our rounds to every chicken joint in the neighborhood. Unable to find her, we ran into one of the client's smoking buddies, who recognized the peer and hailed us down. "I'll tell her that you came around. You know it means something to her, even when she's crackin' like this. You keep comin' around. I'll tell her you said 'hi.'"

By considering instances in which peer relationships led to very different outcomes, it becomes clear that peer relationships were organized by an ethic between peer specialists and clients, and were not governed by conventional notions of progress or outcome. This is not to say that peer specialists did not want clients to "get better," but shows that peer specialists

prioritized compassion over coercion, and personhood over progress. An emphasis upon client empowerment and mutually supportive relationships made it possible for clients to better negotiate the mental health system and meet their own goals.

Clients and peer specialists also developed critical perspectives on the mental health system and their work with professionals and each other. The project facilitator noted:

You can't understand the 'self' or provide the 'help' in self-help without understanding the 'power' in empowerment. Sometimes it's your power; sometimes it's somebody else's. Sometimes it's the power of the system; sometimes it's the power of being a peer and being yourself at the same time.

Even when client perspectives differed dramatically from peer specialist perspectives, and created tensions between peer specialists and clients, peer specialists saw this as evidence of client empowerment. One peer specialist commented, "It's called people thinking for themselves, making decisions that make sense from their own experiences."

Professionals often approached clients by assuming that the client didn't already have their own life, including family relationships, meaningful activity, and/or individual dignity. Peer specialists called this the "get a life" approach, in which the client is assumed to not have a life of his or her own that could be lived without the assistance of a professional social worker. Peer specialists contrasted the "get a life" approach with their own approach of teaching clients "the art of living," described by various peer

specialists as "the art of using and enjoying your time," "the art of self-help," "the art of being yourself when people think you're nobody in particular."

Teaching the many "arts of living" involved not just teaching clients the mechanical skills involved in day-to-day tasks, but also involved showing clients how to enjoy participating in or performing them. This also included a great deal of learning on the part of the peer specialists, who often organized activities with clients that the peer specialists themselves had never done. Thus the provision of peer counseling could not be separated from the provision of other supportive services, the development of the peer specialists' own relationships with clients, or the personal development of each peer specialist into their role on the project.

4e. The Provision of "Concrete Services"

Paraprofessionals assisted a larger number of clients than the peer specialists, but provided a more narrow range of assistance for and interaction with clients. Their roles more closely dovetailing ICM roles, paraprofessionals described their work in terms of providing "concrete services." The adoption of such a term reflected an unspoken but well-understood hierarchy of social services, in which the provision of "things" such as money, clothing, housing, or treatment are seen as more "real" than (and therefore taking priority over) processural and relational services such as counseling, peer support, socialization, leisure activities, and preventative mental health work.

ICMs depended upon the paraprofessionals to help them to navigate through what some ICMs described as "difficult" neighborhoods in the South Bronx and through "difficult" situations with clients. It is interesting that

although peer specialists also offered to ICMs their own first-hand knowledge about traveling in the Bronx, peer specialist contributions were defined by ICMs and peer specialists alike in the original terms of the research grant proposal: namely, that peer specialists would provide experiential knowledge of the mental health system, in contrast to paraprofessionals who would provide experiential knowledge of the community.

The problems of locating and getting clients to accept ICM help organized much of the ICMs' and paraprofessionals' routines. Having the company of paraprofessionals in the field allowed ICMs to discuss their approaches to clients and established a sense of comraderie during travel time. When accompanied by the qualitative researcher on visits to clients, ICMs working with paraprofessionals expressed a sense of relief to have their company in the field. One of the "concrete services" that paraprofessionals and peer specialists offered, then, included these daily supports to ICMs in the field. As will become clearer in the "Helping Out" section below, the peer specialists and paraprofessionals did not only direct their "concrete" or "supportive" services to ICM clients.

ICMs often utilized the paraprofessionals when having to visit clients experiencing crises of various sorts, or when having to visit clients in sections of the South Bronx with which the ICMs were unfamiliar, or which the ICMs were not comfortable visiting alone. Because ICMs often make several "tries" before locating a client, the company of the paraprofessionals was especially welcome. ICMs most often secured the assistance or company of paraprofessionals to visit "unmanageable" clients or individuals living in "precarious, which is to say, shitty" housing situations, as evidenced by the following two examples.

Although we left our ID's at the window at the entrance of this hotel (\$25.00 per night, weekdays), we didn't get to meet the client. The ICM, paraprofessional and I walked up the five flights of stairs to the client's room; no elevator in the building. At each blind spot in the hallways, the ICM paused, listened, then quickly maneuvered into the next hallway, the next stairwell, scanning the bathroom stalls which opened out into the hallway, looking left, looking right, and moving on. No one was around to possibly confront us. The ICM had a key to the client's SRO room, and used it to open the door and leave a note inside, in spite of warnings against such action. On the client's door, a painstakingly hand-printed sign announced:

If you so much as break into my motherfucking place
and mess with my motherfucking things I can not be
held irreparable for my actions.

The ICM took a look around the apartment room, tried to figure out information about her from how the place looked. How many pills left in the ten or twelve orange plastic bottles perched on top of the client's boom box? Unmade bed; thin mattress tossed over a frame with springs; hunting knife stuck blade-down into the window sill, within arm's reach of the bed. On the counter near the sink, toy cars sat situated in a circle, placed carefully on a yellow towel. In the center of the circle of cars stood a coffee mug with a teddy bear poking its head and arms out of the cup. A hot plate was perched on top of a small refrigerator that wasn't working. On the floor, a note to the ICM: "I'm out shopping. So, you stopped by. Well." The ICM left the client a note, locked the door carefully on the way out. Another carefully hand-written sign on the door caught my eye:

Lord, I hope my trying to please you pleases you.
That may be the only pleasure either ones of us
gets in this life anyway. Amen.

Outside the SRO, a young man on the street approached the paraprofessional and asks if she was a social worker. She said yes, and flagged the ICM to come over. The man said last month a woman committed suicide jumping off the roof of the SRO; that the place is charging people regular rates for rooms while receiving subsidies to charge reduced rates; and asked the ICM if they could help him "get out of this place. This is no place for humans. No safe place for people of any situation. People getting stabbed and mugged all the time in there." The ICM gave information about an office to visit nearby, and the young man thanked her and the paraprofessional. He wondered out loud whether his information would get passed on to any "real authorities." "Who's gonna know how bad things are? Are you gonna tell anybody for real what's going on?"

Later in the afternoon, we went to accompany a client to receive her monthly injection of medication. I was told this may become an involuntary hospitalization, as the client, a woman in her late 70s, often refused to take any medication. Before arriving at the apartment, the ICM spotted the client walking to the store, holding onto the elbow of her home house aide. This was a new aide, as the client attacked the one she had before. The ICM and paraprofessional got out of the car, ran up to the client who was picking up her pace, looking over her shoulder, then looking to the next intersection to see if she could lose the ICM as she'd done times before. The ICM called for

her to stop and wait, and caught up to the client. Skillfully, the client made the ICM show the aide her official ICM identification, which took a few seconds---during which the client started jogging in the other direction.

"Stop!" the ICM shouted, and begged the aide to catch the client and stop her. The client screamed directions in Spanish to the aide, who did not know whether to follow the ICM or the client. At that moment, the client's daughter walked up, greeted the ICM, and took her mother by the arm. The paraprofessional told me that the client has attacked this daughter several times, but the daughter still takes regular care of the mother. The client was escorted by the ICM, paraprofessional, home aide, and daughter to the car, where she was led into the back seat. Sitting next to me in the car, the client pointed proudly to her new pair of Nike sneakers, the ones that the paraprofessional helped her pick out, and that occasionally help her make a get-away from professionals.

"Just do it," the ICM told the client at the clinic, where the entire nursing staff waited for the client's decision about the injection. The client surprised everyone by taking the shot, then refused to take a car ride back to her apartment with the ICM. She pointed to her Nikes, turned her back on the ICM, and stiffly walked herself in the direction of home.

A month later, when time for the next medication appointment, she knocked the ICM's glasses off her face, and stepped on them with both her feet. Disappearing into the bathroom, she reemerged with a pill on her tongue, dramatically closed her mouth, and made swallowing motions. The ICM, unimpressed, said "Show me." The client said in English, "Don't worry, I swallowed it," and handed the broken glasses back to the ICM. After this encounter, the ICM encouraged the paraprofessional to make the regular visits to see if the client was taking her medication.

ICMs also did not hesitate to relegate some of their more tedious recordkeeping responsibilities to paraprofessionals. Thus the near absence of struggle in integrating paraprofessionals within ICM teams suggests that paraprofessionals were placed in the lower reaches of familiar professional divisions: those with the least credentials were assigned what professionals considered to be the more physically dangerous and tedious tasks. Over time, paraprofessionals perceived their own disadvantaged educational and socioeconomic status as the basis for ICM acceptance of and willingness to utilize paraprofessionals for certain kinds of work with certain kinds of clients.

Thus paraprofessionals, for different reasons than the peer specialists, met the ICMs' acceptance with a measure of mistrust. As one paraprofessional noted, the paraprofessionals on the whole had better relationships with ICMs they did not work with, because such associations were both voluntary and "not concerned with who is superior or asking 'how can I use you today?'"

This uneven ground of ICM-paraprofessional relations actually provided paraprofessionals with the determination and opportunity to establish with clients the kinds of working relationships paraprofessionals desired but were denied with ICMs. Inspired by their experiences working as colleagues with peer specialists, and dissatisfied with their relationships with ICMs, paraprofessionals worked to establish a sense of personal trust and concern, and yet maintain a professional basis for respect with clients.

This meant that paraprofessionals constantly admitted to clients the various contradictions of the paraprofessional role as both assistant to the client and assistant to the ICM. In their own way, paraprofessionals taught clients about self-advocacy and empowered clients to better work with (and when appropriate or necessary, without) their ICMs. Paraprofessionals

accompanying clients to appointments and clinic visits felt their work further humanized case management and yet underscored both the clients' and the paraprofessionals' own undervalued status within the mental health system.

Citing numerous ways in which professionals stigmatize clients, paraprofessionals noted that approaches utilizing paraprofessionals as "natural" allies of clients contained an empowering potential to link people with knowledge of local resources with people needing local resources. However, realizing this potential with clients sometimes disempowered paraprofessionals as providers. Paraprofessional successes with clients were sometimes jokingly interpreted by professionals as evidence that paraprofessionals had perhaps experienced mental illness, or shared with clients some other factor beyond individual control, such as race, age, or gender. Working relationships between paraprofessionals and ICMs tended to be based on ICMs' personal rather than professional acceptance of individual paraprofessionals.

The so-called resistance or ambivalence of clients was not altogether unfamiliar to paraprofessionals in their own work with ICM clients, but these were met with very different attitudes and gestures by the two groups. A paraprofessional commented that "ICMs want you to judge the clients right off. But that's not how to do things. Plus people change." On a visit to one client's apartment, with the purpose of inviting her to the ICM client picnic, one paraprofessional gave the client different reasons to consider going, after a flat out refusal.

She explains that there will be lots of food,
and it's all free. The client says she can't
afford the tokens to go. Even when the para-

professional explains that she will come to pick the client up, and pay for her way to the hospital, the client declines politely. Says she's feeling sick, that her stomach is acting up and she can't eat picnic food. The paraprofessional writes down her phone number, gives it to the client, says to call in case she changes her mind in the next couple of days. She also talks to the client about doing something fun together, like going out for some food. That doesn't interest the client. The paraprofessional asks what does interest her? The client says music. What kind of music? Gospel. The two discuss different gospel musicals, and the client gets interested in going. "But if it costs \$5 or \$50, it's more than I have." When the paraprofessional tells her she'll pay her whole way, that she gets money from her work, the client can't believe it. Says she'd be uncomfortable having anybody pay her way. The paraprofessional asked the client to think about it. "Now, I know you're just putting me off again. I'd really like to do something fun sometime. And you know, when you get out to do things, your body feels more alive and your mind is clearer, too. You think about it."

Later the paraprofessional wondered aloud whether it really matters if she and the client ever do something like that together. "Maybe all she needs is to know that I come by and want to spend time with her, see how she's doing. Maybe that's all she wants, is to know somebody cares at all." Thus paraprofessionals did not take client refusals as a personal or professional affront, but as evidence that the client was a person with preferences and needs independent of, but not necessarily at odds with, professional mandates. Paraprofessionals honored clients' choices even when these went against "common sense" or professional standards for client behavior.

4f. Recordkeeping

ICMs also assigned recordkeeping tasks to the paraprofessionals, which paraprofessionals considered to be their most tedious but certain tie to professional ranks. Paperwork often occupied the paraprofessionals during project meetings, team/unit meetings, and Hunter College Alumni sessions. Like the ICMs, paraprofessionals could be found filling out forms in almost every spare minute. The responsibilities of keeping client records---progress notes, daily logs, monthly logs, and some chart work---cut into other kinds of work for the paraprofessionals. Whereas peer specialists made entire visits with clients in order to talk with and listen to them, para-professionals usually only had "that kind of time" for clients either during travel time to and from appointments or at the end of scheduled home visits.

Peer specialists did not get involved in extensive recordkeeping until the second year of the project, when the new project facilitator took on her role. For the first two years of the project, peer specialists kept their own notebooks (daily logs) of interactions with clients; however, these were

informal records. The new facilitator insisted that peer specialists hand in monthly reports as required for the paraprofessionals. Because the new ICM coordinator (who began to supervise the peer specialists' ICM team in 1992) felt the official monthly report forms were inappropriate for peer specialists to use, the new facilitator developed her own monthly report form. This form was acceptable to the new ICM coordinator, and was acknowledged by the Office of Mental Health as an innovation. Keeping daily logs and filling out monthly reports was also seen by the peer specialists as a way to demonstrate the "realness" of what they do for and with clients. "It may not be concrete services, but these services are very, very real."

Peer specialists' initiation into recordkeeping also blurred a previously clear-cut distinction maintained between peer specialists and paraprofessionals, and made peer specialists appear to be what one ICM described as "patient professionals rather than professional patients." In other words, recordkeeping played an important role in ascribing professional status to these two groups of staff. Peer specialists acknowledged this in their own terms, noting the importance of having access to client records in order to better advocate for clients, and the potentially constructive power of helping build client records themselves.

4g. "Helping Out Upstairs"

Peer specialists were sometimes called upon to "help out" the ICM program by providing secretarial services on the 6th Floor ICM ward. When the ICM secretary did not come in and a replacement could not be secured, ICM coordinators called on peer specialists to answer the phones, xerox records, and do other office tasks. During an ICM conference held at the

hospital, peer specialists were asked to "man" the registration desk and sign in participants.

Initially, peer specialists gladly assisted on the ICM ward when requested. However, during the final year of the demonstration project, peer specialists became increasingly unavailable for such work. For one, the peer specialist team realized that the female peer specialists were primarily the ones relied upon to answer phones, etc. The peer specialists finally refused to assist in these ways, arguing that they were not being treated like professionals, and intimating that their secretarial help "enabled" the ICM program to maintain a "last-minute" approach to its own staffing.

Nevertheless, peer specialists felt an enormous obligation to assist ICMs in these ways, and the secretarial ties were never completely cut. When peer specialist involvement in recordkeeping increased, however, peer specialist involvement in secretarial assistance to the ICM program lessened. In this way, peer specialists insisted upon primarily dedicating their work time to the ICM clients, and sustained their belief that peer specialists existed to serve clients and not the ICM program per se. Peer specialists deflected requests to answer ICM telephones by explaining that they had to honor appointments made to visit clients and refusing to reschedule such visits.

4h. Project Facilitation

The first project facilitator, working to implement the peer specialist project in its first year and a half, helped to successfully integrate peer specialists and paraprofessionals into ICM partnerships and identify peer specialist and paraprofessional roles with clients in the field. It is also significant that the initial project facilitator established the facilitator role as

both a supervisory and advocacy position, networking beyond the peer specialist project itself to promote consumer issues and the peer specialist program model.

In April 1991, the project facilitator left his position to attend to medical needs. The news of his leave was met with concern and grief within the peer specialist project. Peer specialists, paraprofessionals, research staff and management staff from the Bronx to Albany rallied together to support the project facilitator and each other at a moment of profound ambiguity within the project. The absence of the one individual who had been "the glue" of the project---"like a father to us"---resulted in weeks of confusion within the peer specialist project.

The management team promoted one of the peer specialists to become the second project facilitator. In light of this promotion, project staff rededicated themselves to the project. Because the new facilitator took on the task of maintaining continuity within the peer specialist project, a sense of comraderie amongst the counselors, continued collaboration with the ICMs, and a renewed sense of purpose became primary. By establishing recordkeeping systems for the peer specialists, advocating for increased and ongoing respect of peer specialists and paraprofessionals, and bringing a family spirit to the peer specialist project itself, the second project facilitator succeeded in a most difficult task. The integrity of both professional and personal relationships on the project were strengthened in the process.

During and beyond the course of this study, the second project facilitator (referred to as "the project facilitator" below) took a leadership role in supporting and directing peer specialists and paraprofessionals, and actively worked to maintain productive relationships between state Office of Mental Health and hospital administrators, ICM coordinators, ICMs, peer

specialists, paraprofessionals, and clients. The project facilitator met once per week with the peer specialist project director. Together the facilitator and director prepared for project management meetings and made decisions about program development and implementation.

The project facilitator also held weekly staff meetings with peer specialists and bi-monthly staffings with paraprofessionals, and met regularly with the qualitative researcher to discuss and help implement the evaluation study. By giving feedback to members of the management team, ICM teams, counselors, and research staff, the project facilitator established a sense of unity on the project, and sustained the primacy of consumer perspectives within the project.

The project facilitator also attended to practical and interpersonal issues which arose between counselors, ICMs, clients, and others. Counselor relationships with ICMs needed ongoing attention during the project. Both groups of counselors experienced insults communicated through gestures or subtle comments, or comments not intended but nonetheless communicated as insults--which resulted in their favoring public transportation when possible. The pregnancies of the two women paraprofessionals brought extended rounds of teasing and criticism from ICM staff who commented in front of colleagues that "the paraprofessionals must be good at something else besides social work" and reminded the paraprofessionals that "it was about time" Black women stop having "so many children."

Such comments were especially unwelcome, and grew to mythic proportions within the peer specialist and paraprofessional ranks. When one ICM staff raised the topic of abortion to one paraprofessional the counselors, after extensive discussions about sexism as a form of stigmatization experienced by women, re-affirmed their determination to serve the needs of

clients as opposed to the needs of the ICM program. Such experiences also strengthened supportive relationships between peer specialists and paraprofessionals.

The project facilitator, sometimes in concert with the project director, assisted the counselors in sustaining working relationships with their ICMs by listening to counselor and ICM concerns. Mediation of relationships anticipated to be tension-ridden and expected to be transformed by peer specialist interventions at times proved to be a diplomatic feat. Ever aware that the project and the counselors were breaking new ground, the project facilitator encouraged ICM-counselor communication when possible, and discussion of ICM-counselor issues at management meetings only when necessary.

5. Professionalization of Counselors

5a. Hunter College ICM Alumni Training Sessions

After completing the required training to receive the ICM certificate, counselors and ICMs attended the Hunter College Alumni training sessions. At these, counselors and ICMs attended monthly presentations and workshops intended to sensitize attitudes about and better inform professionals' work with clients. These regular sessions provided counselors an opportunity to demonstrate their professional status by articulating their knowledge of clients, social work practice, and regional issues. However the opportunity to speak at alumni sessions became a charged experience, especially for peer specialists.

Representing consumer perspectives often meant addressing critical comments to the guest speakers or to ICM colleagues from other programs.

By participating in the alumni sessions, peer specialists met the difficult task of representing client concerns and promoting client autonomy in the company of professionals whose own identities and professional status depended upon managing clients. Thus peer specialists in particular took the Hunter College sessions as opportunities to broaden their own knowledge of social work and sharpen their strategies in working with professionals.

A rather familiar atmosphere structured the speeches and discussions at the alumni trainings. While ICMs from the Bronx carefully counted whether each and every counselor was present at each session, many ICMs at the sessions completed paperwork during speeches or caught up with colleagues. Yet in this atmosphere there seemed to be an imperative for counselors to prove themselves as professionals, and for peer specialists specifically to prove themselves as professionals and knowledgeable consumers.

The individual workshops provided counselors with a very clear picture of how professionals discuss clients and approaches to clients within a closed atmosphere similar to that of case conferences. In a case conference at one alumni session, the workshop facilitator attempted to sensitize ICMs to the client's perspective and the social conditions which might support or explain client behaviors or lack of progress. The facilitator passed out a sheet giving a case description, and asked ICMs to identify the client's goals. ICMs named various goals for this client, as summarized in qualitative fieldnotes.

The client is at a crossroads. He's ready to work through his resistance to social services. He's ready to get into treatment.

At these suggestions, the facilitator noted that these are the ICM goals, not the client's goals. What might the client's goals be?

Client's goal is to gain interventions. He is afraid of service providers. He needs to admit he has a drinking problem. There's a change, but it's not total. Why? Is it the client's ambivalence about social services?

At this point, a peer specialist brought to the attention of the group the paucity of client information in the case description, noting that the case summary failed to identify the client's social relationships outside of the family, their nature, strength, reliability, and meaning to the client. She also pointed out that the case summary did not describe a single strength of the client.

Even after this comment, discussion continued without pause.

The client's goal is to keep taking medication.
The client's goal is to overcome being ambivalent to psychiatric treatment. One ICM puzzled over the "motivating factor" of this client's behavior, assuming that the change was originated through the ICM.

When the case conference facilitator suggested alternative interpretations of the client's situation and motivation, the ICMs responded with what might be called clinical hostility.

Facilitator: Perhaps these are coping behaviors, related to survival. Remember that the client never had a mother, and lives in a city where African-American men don't fare well.

ICMs responded with the following comments:

The client wants someone to do it all for him.

The client sets it up so he needs help.

He's a classic MICA who's acting out and has set this up himself.

He's learned to negotiate the system, but he's self-destructive.

He's not ready for what he wants.

Let him make his own choices; let him self-destruct.

His goal is to leave the house, but he seems very paranoid as a way of life.

When the case conference facilitator then asked what might be some of the client's strengths, ICMs stated the very same factors that they had earlier discussed as barriers to service provision.

He's manipulative.

He must be likeable for the ICM to work with him at all.

He hasn't given up, although he should in order to accept his illness.

The father does take him back in. (The case summary noted that the father often threatened the son/client

with a gun, occasionally shooting it when the son was in the house.)

He's not bizarre. When a client's bizarre, they're hard to like, and it's hard to go out with them in public, and get them hooked into services.

After such a listing of "strengths," one ICM in the conference thought he recognized this client as one of "his." "I had another client who was a lot like this one. He lived in decadence in a roach-infested apartment for years."

ICMs' own professionalism rested upon their ability to identify and manage clients' problems and weaknesses, and then make the leap to identify client strengths. ICM descriptions of clients derived not from individuals' attitudes, but from assumptions built into the ICM program, such as the assumption that their clients would never fully recover or gain control over their lives. ICM program policies, for example, initially established that only in the case of a client death, or if the client initiates a formal, written process to request termination, can a client be terminated from the ICM program. (Only recently has this strict rule been relaxed somewhat.) Thus ICM approaches to clients existed in the context of permanent client participation in the program. Under the initial policy of keeping clients on "for life," ICM assessments of clients' behaviors as posing life-long barriers to treatment and recovery emerged.

In such a context, peer specialists and paraprofessionals experienced mixed feelings about their own professionalization. For one, even though the counselors completed the ICM training sessions, they did not receive the ICM certification, for lack of required educational credentials. At the Hunter

College sessions, counselors sought out the workshops that would be most informative and helpful in their work with individual clients, and enjoyed socializing with ICMs from various programs around the city. The Alumni sessions also provided counselors with the opportunity to present themselves as a team to the ICM "community"---a reminder to professionals and to themselves that there is strength in numbers, even from the margins of the profession.

5b. "Going To Conferences"

Peer specialists, as stipulated in the original demonstration grant proposal, attended numerous professional mental health and consumer/self-help movement conferences. The peer specialists attended events sponsored by New York State Office of Mental Health and the Mental Health Association of New York State, as well as local and national conferences sponsored by other professional and consumer organizations. Initially, the original peer specialist project facilitator (sometimes with the project director) attended such events on behalf of the project. However, when the second project facilitator took the position, she identified that there was money budgeted for peer specialists to attend conferences as well. Attendance at conferences depended upon budgetary considerations, individual peer specialists' interests, and the availability of individuals on a given date.

At such conferences, peer specialists participated by giving speeches, reports, and accounts of their work in the Bronx. In addition to their attendance of project management meetings, peer specialists included conference attendance as work they do "for the project." Peer specialists initially considered "going to conferences" as an honor, but eventually also

came to see their participation at professional conferences as a form of tokenism.

The presence of peer specialists and paraprofessionals at professional conferences was exceptional at several levels. Because at most meetings, few consumers, consumer-providers, low-income individuals, people of color or members of (so-called) ethnic minorities, or individuals hailing from New York City or The Bronx attended, counselors experienced significant personal isolation at conferences. At one conference, participants' nametags gave each person's name, affiliation and job title, and locale; however, nametags for counselors from the Peer Specialist project simply gave each person's name followed by "Bronx." Practical differences in how project staff were treated at conferences took on symbolic importance to the counselors, as people discussed what each delay or omission or comment might mean "in the larger picture."

In spite of logistical problems occurring at nearly every conference attended, counselors enjoyed each others' company immensely, taking the travel time as a chance to relax with each other and have fun. Some of the best memories from the project were formed in these times of "going to conferences," as people revelled in the friendships that, in such a context, could take priority over any other roles.

As counselors' awareness of the intricacies of state mental health politics grew and sharpened, counselors maintained a cautious yet congenial posture with professionals at local, regional and state conferences. Over and again, peer specialists and paraprofessionals listened to conference speakers "talk about us but not to us. Then when we say something, we're like a label speaking. Consumer. Black. Bronx. Next."

Peer specialists acknowledged that at conferences, they were ascribed a rather narrow political role. "We don't go to these conferences to advocate for clients, because you really can't do that at conferences. There usually aren't even any clients there." Instead, conference attendance was seen to benefit the peer specialists as individuals and, through peer specialist representation, the peer specialist and ICM programs.

Consumer conferences proved a contrast to professional conferences, as peer specialists met with people with similar experiences, interests, and difficulties within the profession. Peer specialists reported the atmosphere at the consumer conferences to be more congenial to discussion, but noted that consumer and professional conferences had various success at letting everyone speak out and be heard. "You could say the politics are different, but there are still politics occurring, either way," one peer specialist remarked. However, the ability to network with one's peers was considered invaluable to peer specialists and the project facilitator, who developed extensive ties to other consumers and professionals supporting consumer advocacy.

The initial gratefulness with which peer specialists accepted invitations to professional mental health conferences waned after numerous experiences of logistical problems formed a clear pattern in the mind of the peer specialists. Essentially, attending conferences came to be seen as another aspect of peer specialists' job responsibilities. "They say these conferences are opportunities, and it's true. Another opportunity to work." In other words, conferences ceased to be seen as special events or events that made the peer specialists special people. "You're usually invited for someone else's reason," one peer specialist commented.

It is interesting that going to conferences did not fit into the schema of working in the office or working in the field. "So, this is working in the

profession." As professional spaces, conferences evoked contradictory experiences and feelings for peer specialists. On the one hand, they became more informed about and connected within the mental health profession. Yet the barriers to self-representation at conferences were great, even when peer specialists had the floor.

As work, attending conferences proved tiring and frustrating. As opportunity, conference attendance reminded peer specialists that they were people in search of opportunity rather than people distributing opportunity. The few times that peer specialists and paraprofessionals attended conferences together, the team spirit was strong, and the antagonisms with other conference participants and conference missions were even stronger. Supported by each others' company, peer specialists and paraprofessionals attended conferences with a mindset similar to that held by any number of conference participants who were not representing demonstration projects. "Professionals don't lose their minds over going to a two-day conference. Why should we?"

Taking these experiences home, the project facilitator, in collaboration with local mental health agencies, organized a local mental health educational conference in the Bronx, which drew both professional and community participants, and received local news coverage. Consumers comprised over half the participants and filled the speakers list. Giving the audience a very different picture than the one painted at most professional conferences, the peer specialist project facilitator noted:

The consumer movement did not start in Albany,
and it did not start in Washington, D.C. It started
on the wards where people really started supporting

each other. It started in the community when people got out of the hospital. We've all gone through different problems, but we're all ONE!

After finishing her introductory speech, the peer specialist project facilitator opened the conference by filling the auditorium with tape-recorded music. People stood up from their chairs, swayed to the sounds, and raised their voices singing "I Am Everyday People."

Thus the often disempowering experience of attending professional mental health conferences as the sole consumer or peer specialist representative became a springboard for peer specialist and project facilitator mobilization of a different vision of professional and consumer collaboration. At the community conference, all brought different resources, needs, and questions to the common cause of community empowerment and survival. As the parent of one consumer activist explained to the conference participants, taking a community-based approach to mental illness "means making sure we're all alright...the community is involved in the treatment of the person and the community."