

# Wisconsin Certified Peer Specialists

## Employer Toolkit

*How to successfully hire, integrate and support Certified Peer Specialists*

---



**Peer Specialists**  
*Igniting Recovery*



**DIVISION OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES**

1 WEST WILSON STREET  
PO BOX 7851  
MADISON WI 53707-7851

Telephone: 608-266-2717  
FAX: 608-266-2579  
TTY: 888-241-9432  
dhs.wisconsin.gov

Scott Walker  
Governor

Kitty Rhoades  
Secretary-Elect

**State of Wisconsin**  
Department of Health Services

Dear Employer,

In anticipation that you are reading this Wisconsin Certified Peer Specialists Employer Toolkit as a precursor to hiring a Certified Peer Specialist, I must thank you. You are choosing to embark on a path that will not only employ a Certified Peer Specialist, but one that will see your program increase the understanding and role modeling of recovery principles. The use of the evidence based practice of peer support will improve outcomes and most importantly give the consumers you work with someone that is a role model and can help instill the hope and knowledge that recovery is possible.

As Section Chief for the Bureau of Prevention Treatment and Recovery, in the Division of Mental Health and Substance Abuse Service, in the Department of Health Services, it has been my privilege to be involved in the Wisconsin Certified Peer Specialist Employment Initiative for consumers with lived experience with mental illness and/or substance use disorder. The Bureau has been instrumental in creating, certifying and promoting the use of Certified Peer Specialists in Wisconsin. While this initiative gives individuals with lived experience a career path, as you will soon find out, it gives programs and the Wisconsin Mental Health and Substance Abuse System so much more.

As an employer, you will find this toolkit to be an essential resource in your employment of a Certified Peer Specialist (CPS). It will assist you in integrating and supporting the CPS as part of your staff, clarify terms and practices for you and other useful information that will assist you in successfully hiring a CPS. The toolkit is a composite of timely and practical information that was developed by the Wisconsin Employer Toolkit Advisory Committee, many who are employers working in the mental health field and reviewed by the Wisconsin Peer Specialist Advisory Committee of which a number of CPSs are members.

Thank you to the members of both committees for their hard work on this initiative and toolkit. Thank you for considering hiring a Certified Peer Specialist.  
Sincerely,

Kenya Bright MS, CSW  
Section Chief  
Bureau of Prevention Treatment and Recovery

## Table of Contents

<b>Introduction.....</b>	<b>2</b>
<b>History of the Wisconsin Certified Peer Specialist Employment Initiative.....</b>	<b>3</b>
<b>The Professional Role of a Wisconsin Certified Peer Specialist.....</b>	<b>4-13</b>
<b>a. Employment Areas and Service</b>	
<b>b. Core Competencies</b>	
<b>c. Code of Conduct</b>	
<b>d. General WI Certified Peer Specialist Job Description</b>	
<b>Rural Community Employment.....</b>	<b>14</b>
<b>Preparing Staff for the Inclusion of a Wisconsin Certified Peer Specialist.....</b>	<b>16</b>
<b>Creating a Stigma-Free Workplace Environment.....</b>	<b>17</b>
<b>Supervising and Supporting the Wisconsin Certified Peer Specialist.....</b>	<b>18-19</b>
<b>Recertification Requirements for Wisconsin Certified Peer Specialists.....</b>	<b>19</b>
<b>Living Wages and Benefits/Work Incentive Benefits Counseling.....</b>	<b>21</b>
<b>ADA Job Accommodations.....</b>	<b>21</b>
<b>Funding/Billing for Wisconsin Certified Peer Specialist Services.....</b>	<b>22</b>
<b>Organizational Self-Assessment tool.....</b>	<b>23</b>
<b>Resources.....</b>	<b>26</b>
<b>References.....</b>	<b>30</b>
<b>Attachments.....</b>	<b>31</b>

## Introduction

Thank you for your interest in the Wisconsin Certified Peer Specialist Employment Initiative.

This Employer Toolkit is designed to help you assess your agency’s readiness to successfully hire, integrate and support a Wisconsin Certified Peer Specialist as part of your staff and services.

The Toolkit clarifies terms and practices that define a recovery-oriented workplace, provides practical guidance for service implementation, and resource references. An agency committed to focusing on mental health recovery can develop a staff support plan that addresses the needs of all staff members including staff selection, training, ongoing coaching and supervision, program evaluation and continuing education.

Thank you to the Wisconsin Employer Toolkit Advisory Committee, Julianne Carbin, Dan Baker, Val Levno, Steve Dakai, Kathy Knoble-Iverson, Dee Barnard, Alice Pauser and Joan Sternweiss for their expertise in researching and developing this Toolkit. The Toolkit was reviewed by members of the Wisconsin Peer Specialist Subcommittee (of whom several are WI Certified Peer Specialists) of the Recovery Implementation Task Force and approved by the Wisconsin Department of Health Services Bureau of Prevention, Treatment and Recovery.



## **History of the Wisconsin Certified Peer Specialist Employment Initiative**

In 1996, Wisconsin Governor Tommy Thompson formed the Blue Ribbon Commission on Mental Health. This body was charged with examining how Wisconsin's mental health services could be improved and recommended that Wisconsin services focus on the recovery process. These recommendations underscore the importance of providing Peer Specialist services to service recipients.

Wisconsin recognizes Peer Specialists in the Comprehensive Community Services Rule and is working to incorporate this provider position throughout the service system. Through a Medicaid Infrastructure Grant, funding was available to develop a Certified Peer Specialist program in Wisconsin. The Peer Specialist Committee was formed through the Wisconsin Recovery Implementation Task Force (RITF) to develop and implement the steps necessary to have a certification program and begin an employment initiative to have Certified Peer Specialists hired onto mental health recovery teams in the public and private sectors.

In 2009 the Wisconsin Department of Health Services, Division of Mental Health and Substance Abuse Services agreed to hold the certification for Peer Specialists. This certification states that a person has passed the approved training and certification exam. Certified Peer Specialists are also required to complete continuing education hours based on the program's core competencies in order to maintain their certification. All Certified Peer Specialists agree to adhere to the program Code of Conduct (page 9).

The first Certification Exam was proctored in January 2010. This was done in partnership with The UW-Milwaukee, who houses the exam and the eight WI Independent Living Centers who proctor the exams online three times a year.

The exam is based on the WI Peer Specialist Training Core Competencies that cover eight domains and objectives:

1. Self-Knowledge and The Role of the Peer-Specialist
2. Ethics and Boundaries
3. Cultural Awareness
4. Advocacy and Ability to Locate Information
5. Teamwork
6. Service Recipient Choice and Empowerment
7. Crisis and Safety
8. Recovery

Wisconsin Certified Peer Specialists provide recovery-oriented services to peers.

## **The Professional Role of a Wisconsin Certified Peer Specialist**

**A Certified Peer Specialist** is a person who has not only lived the experience of mental illness but also has had formal training in the peer specialist model of mental health supports. They use their unique set of recovery experiences in combination with solid skills training to support peers who have mental illness. Peer Specialists actively incorporate peer support into their work while working within an agency's team support structure as a defined part of the recovery team. When a Certified Peer Specialist is involved as an integral part of a person's recovery plan, statistics show that there is a reduction in hospital stays and emergency room visits and individuals stay in recovery for longer periods of time.

**A Certified Peer Specialist** is a job title within the agency of employment where the role of a peer specialist is specific to the lived experience of that specialist and how that experience is used to help others move forward on their recovery journey. **Peer support must be the core of every task performed by the WI-CPS.**

**The Role of the Certified Peer Specialist** is varied and can take on several forms of support and assistance. Although roles may vary in service agencies, it is generally recognized that Certified Peer Specialists provide the following services:

- Use personal recovery experience as a tool
- Provide information about mental health resources
- Assist in identifying and supporting consumers in crisis
- Facilitate self-direction and goal setting
- Communicate effectively with other treatment providers

The WI-CPS engages and encourages mental health service recipients in recovery and the WI-CPS provides service recipients with a sense of belonging, supportive relationships, valued roles and community. The goal is to promote wellness, independent living, self-direction, recovery focus, enhancing the skill and ability of service recipients to meet their chosen goals. WI-CPSs work from a strength-based perspective and embody the belief that recovery is possible. In most situations the WI-CPS must be supervised by a qualified mental health professional as defined under Medical Assistance.

WI-CPSs are employed staff who serve individuals who have been assessed as having potential positive outcomes by working with a WI-CPS. This role is professional in nature and supports are delivered by the WI-CPS. Wisconsin Certified Peer Specialists actively use peer support to engage with the participant. WI-CPSs utilize their personal journey as part of the process of peer support but never allow their journey to become the center of the relationship with the participant.

WI-CPSs use their unique set of recovery experiences in combination with solid skills based training to support peers who have experienced mental illness. They work within the team environment to assist people in their work towards their goals. It is strongly suggested that a WI-CPS inform service recipients of their duty to report issues of potential harm to the participant. It is the expectation for all Wisconsin WI-CPSs that they contact the supervisor if there is concern about health or safety issues. WI-CPSs are not mandated reporters but work under the understanding that supervisors usually are.

Certified Peer Specialists come from many walks of life and have a broad range of skills and talents that benefit the treatment team. Employers are encouraged to integrate the services of WI-CPSs into their agencies while remaining aware that the WI-CPS is the only member of the team who can provide peer support.

**Areas where Certified Peer Specialists are employed include:**

- In and Outpatient Care
- Veteran's Hospitals
- Supported Living Arrangements
- Prisons and Forensic Areas
- CRS-Community Recovery Services
- Homeless Shelters
- Tribal Community Health Care
- Drop-in Centers and Clubhouses
- CSP-Community Support Program
- CCS-Comprehensive Community Services
- ADRC's-Aging and Disability Resource Center
- Independent Living Centers
- Family Care
- Crisis Stabilization and Respite programs

**Technical Assistance for Wisconsin Employers:**

If you would like to receive Technical Assistance regarding hiring, integration and supporting WI-CPS please use the Technical Assistance Request form in the Attachment Section of this Toolkit.

## Wisconsin Peer Specialist Core Training Competencies



The Core Training Competencies were developed in order to provide training curriculums with the areas that must be covered in order to prepare individuals with the knowledge and skills development to qualify to take the Wisconsin Peer Specialist Certification Exam.

### WISCONSIN CORE TRAINING COMPETENCIES

#### Values:

Believe in the importance of self-directed services

Have an outlook on life that inspires hope

Believe that growth and change are possible

Believe in the healing power of relationships

Accept and embrace differences

Believe in the importance of the persons choices

Have respect for all cultures, sexual orientations, spiritual beliefs, and family cultures regardless of personal beliefs

Believe that recovery is possible for all

Have respect for human rights

#### Personal Attributes:

Is able to use own recovery experience and skillfully share to benefit others

Has self-awareness and is able to use to inspire others

Is able model wellness

Possesses problem-solving skills to assist people in exploring life choices, and the outcomes of those choices

The ability to embrace and support own recovery

Explore, communicate and respect personal boundaries

Balances personal recovery while supporting someone else's

Is able to support people to empower themselves

Recognizes others strengths and challenges

Seeks lifelong learning and personal development



**Knowledge:**

In-depth knowledge of recovery principles
Ethics, boundaries, and healthy relationships
Awareness that there is a range of views and beliefs regarding mental health and/or substance use and their treatment, services, supports and recovery
Understands that recovery and wellness involves the integration of the whole person including spirituality, physical health, sexuality, and community
Knowledge of the impact of trauma on recovery and resiliency
How to support a person to find information about a variety of community resources
General understanding of rights- as defined by a combination of patient rights, ADA standards and civil rights as afforded to all citizens
Cultural awareness-have a basic knowledge of diverse cultures (including age) and how they may impact individual values, choices and lifestyles.
Understands the impact of stigma, discrimination, marginalization and oppression that society places upon individuals labeled with mental illnesses and / or substance use disorders. Understand that self-stigma is the defining of ones self by diagnosis, limitations and/or illness based perceptions.
Role of a Certified Peer Specialist –as defined by the essential functions outlined in the General Wisconsin Certified Peer Specialist Job/Position Description
Safety (Personal and Practices)-knowledge of how to encourage safe environments, relationships and trauma-free interactions for the Peer Specialist and others involved
Person Centered Planning-knowledge of the Person Centered Planning principles and the central role of the service participant

**Skills:**

Communication: ability to listen and to communicate clearly with others both verbal and written
Ability to identify strengths and needs
Ability to connect and engage with a person
Ability to teach and support a person to find and utilize resources
Ability to identify and support people in crisis and know when to facilitate

a referral
Ability to advocate with others
Ability to find information about mental health and substance use support options and alternatives
Ability to use own lived experience in useful way
Ability to foster relationships and engage peers in their recovery
Ability to interact with people in a way that is trauma free
Ability to recognize limitations and boundaries and facilitate referrals
Ability to work collaboratively/participate on a team

This Core Competencies document was developed and written by the Peer Specialist Subcommittee of the Wisconsin Recovery Implementation Task Force in 2008 with funding from the Centers for Medicare and Medicaid, Medicaid Infrastructure Grant # 93.768, Department of Health Services/Pathways to Independence



Updated by The Peer Specialist Subcommittee of the Wisconsin Recovery Implementation Task Force...July 9, 2013.

## **Wisconsin Certified Peer Specialist Code of Conduct**

### **For Mental Health and Mental Health/Substance Use Disorder Peer Delivered Services\***

The following principles serve to guide the decisions and behaviors of Certified Peer Specialists. The Code of Conduct supports the values and principles that WI-CPSs uphold in their professional roles.

1. The primary responsibility of Peer Specialists is to help service recipients understand recovery and achieve their own recovery needs, wants and goals. Peer Specialists will be guided by the principle of self-determination for each service recipient.
2. Peer Specialists will conduct themselves in a manner that fosters their own recovery and will maintain personal standards that are respectful to self and community.
3. Peer Specialists will be open to share with service recipients and coworkers their stories of hope and recovery and will likewise be able to identify and describe the supports that promote their recovery and resilience.
4. Peer Specialists have a duty to inform service recipients when first discussing confidentiality that contemplated or actual harm to self or others cannot be kept confidential. Peer Specialists have a duty to accurately inform service recipients regarding the degree to which information will be shared with other team members, based on their agency policy and job description. Peer Specialists have a duty to inform appropriate staff members immediately about any person's possible harm to self or others or abuse from caregivers.
5. Peer Specialists will never intimidate, threaten, harass, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to the service recipients they support.
6. Peer Specialists will not practice, condone, facilitate or collaborate in any form of discrimination on the basis of ethnicity, race, sex, sexual orientation, age, religion, national origin, marital status, political belief, disability, or any other preference or personal characteristic, condition or state.
7. Peer Specialists will advocate with service recipients so that individuals may make their own decisions when partnering with professionals.
8. Peer Specialists will never engage in any sexual/intimate activities with service recipients they support. While a service recipient is receiving services from a Peer Specialist, the Peer Specialist will not enter into a relationship or commitment that conflict with the support needs of the service recipient.
9. Peer Specialists shall only provide service and support within the hours, days and locations that are authorized by the agency with which they work.

10. Peer Specialists will keep current with emerging knowledge relevant to recovery, and openly share this knowledge with their coworkers and service recipients. Peer Specialists will refrain from sharing advice or opinions outside their scope of practice with service recipients.
11. Peer Specialists will utilize supervision and abide by the standards for supervision established by their employer. The Peer Specialist will seek supervision to assist them in providing recovery oriented services to service recipients.
12. Peer Specialists will not accept gifts of money or items of significant value from those they serve. Peer Specialists do not loan or give money to service recipients.
13. Peer Specialists will not discuss their employment situation in a negative manner with any service recipient.
14. Peer Specialists will protect the welfare of all service recipients by ensuring that all their conduct will not constitute physical or psychological abuse, neglect, or exploitation. Peer Specialists will provide trauma informed care at all times.
15. Peer Specialists will, at all times, respect the rights, dignity, privacy and confidentiality of those they support.

\*The Wisconsin Certified Peer Specialist Code of Conduct was developed by the Wisconsin Peer Specialist Subcommittee and approved by the WI Department of Health Services/Bureau of Prevention, Treatment and Recovery.

# **General Wisconsin Job Description for Adult Certified Peer Specialists**

## **General Position Description**

This Position Description is a sample of the functions of a Wisconsin adult mental health Certified Peer Specialist. Tailoring would be necessary to fit the unique mission and position at your agency.

Remember:

- Employers should also be familiar with the Code of Conduct that WI-CPSs are bound to.
- This job description describes the roles and functions of a WI-CPS and allows for employment environmental differences.

**Title of Position:** Wisconsin Certified Peer Specialist (Paid Evidence Based Practice Position)

**Job Summary:** The Wisconsin Certified Peer Specialist (WI-CPS) engages and encourages mental health peers in recovery, and the WI-CPS provides peers with a sense of community and belonging, supportive relationships, and valued roles. The goal is to promote wellness, self-direction, and recovery and to enhance the ability of peers to meet their chosen goals. The WI-CPS works with peers as equals. In some programs, the WI-CPS must be supervised by a qualified mental health professional.

**Peer support must be the core of every task performed by the WI-CPS.**

### **ESSENTIAL FUNCTIONS:**

#### **Providing Support**

**The Certified Peer Specialist will:**

1. Identify as a person in mental health recovery.
2. Be mindful of the ethics, boundaries, power and control issues unique to the WI-CPS role.
3. Establish healing relationships with peers.
4. Assist peers to understand the purpose of peer support and recovery models.
5. Provide peers with the Substance Abuse and Mental Health Services Administration (SAMHSA's) definitions of recovery and its components.
6. Intentionally share his or her own Recovery Story as appropriate to assist peers, providing hope and help in changing patterns and behaviors.
7. Create an environment of respect for peers which honors the persons for taking charge of their own lives.
8. Mutually establish acceptable boundaries with peers. Revisit boundaries on an ongoing basis.
9. Be trauma informed and explore with peers their experiences and support these individuals in getting appropriate resources for help.
10. Have and use his or her own recovery/wellness plan which also includes a proactive crisis plan.

11. Encourage peers to construct their own recovery/wellness plans which also include proactive crisis plans.
12. Support peers in crisis to explore options that may be beneficial to returning to emotional wellness.
13. Provide culturally sensitive and age appropriate services specific to each peer.
14. Provide an environment of recovery, wellness and hope.
15. Encourage peers to become self-directed, focus on their strengths, exercise use of natural supports, develop their own recovery goals and strengthen valued roles within their community.
16. Use active listening skills.
17. Together research and locate resources that are beneficial to peers' needs and desires.
18. Understand and be able to explain the rights of the peers.

### **Communicating with Supervisors and Interacting with Staff**

#### **The Certified Peer Specialist will:**

1. Understand and utilize the established supervisory hierarchy to communicate needs, ask questions (especially about ethics, boundaries, and confidentiality) mention concerns, etc.
2. Understand his or her role and fully participate as an integral part of the professional recovery team.
3. Provide education to staff that recovery is achievable and that peer support is an Evidence Based Practice.
4. Accurately, respectfully, punctually complete all required documentation.
5. Work with peers and staff to develop healing and trauma free relationships.
6. Report all peers' threats to harm self or others immediately to the appropriate person.

### **Demonstrating Confidentiality**

#### **The Certified Peer Specialist will:**

1. Be familiar with Wisconsin documents relating to confidentiality. Be very knowledgeable of all confidentiality directives from his or her own agency.
2. Maintain the utmost confidence concerning all verbal and written information whether obtained from peers or otherwise.
3. Be knowledgeable of information that is not to be kept in confidence: threats to harm self or others, and know how to handle these situations.

**Preferred training/skills/experience:**

1. Computer skills (internet, email, Word)
2. Group facilitation or co-facilitation experience.
3. Knowledge of a variety of methods of creating wellness/recovery plans and a variety of methods of teaching others to create their own plan.
4. Basic knowledge of how to assist peers with locating community resources (i.e. employment, housing, health, peers delivered services)
5. Work or volunteer experience providing peer support.

\*The job description was updated and approved by the Wisconsin Peer Specialist Subcommittee of the Wisconsin Recovery Implementation Task Force in November 2012.

**Technical Assistance for Wisconsin Employers:**

If you would like to receive Technical Assistance regarding hiring, integration and supporting a WI-CPS please use the Technical Assistance Request form in the Attachment Section of this Toolkit.

## **Rural Certified Peer Specialist Issues**

*Thank you to Andrew MacGregor, Program Director of Ashland Community Support Program and Val Levno, Program Director of Bayfield Community Support Program, for providing assistance in this area.*

The factors to consider when employing a Certified Peer Specialist (WI-CPS) in a rural setting are not that different from more urban areas. The primary consideration is one of establishing and maintaining appropriate professional boundaries. Issues specific to both employers and employees will follow.

A significant issue faced by service providers in rural settings is transportation and the travel time/distance that is required to help participants access services. Employers need to consider the appropriate way to address these questions.

- Employees must have access to reliable transportation (either their own or an agency vehicle). If employees are required to use their own vehicle to transport people to appointments, then they should be reimbursed in a fair and equitable way. Are they able to be covered under the agency's liability policy? Do they have access to auto insurance, even if they do not own a vehicle?
- The travel time and distance required to help participants access services needs to be factored in to the time that a WI-CPS works for the agency. If the employee has a specific number of hours allotted to work on a weekly or monthly basis, that should be factored in to their work schedule.
- Rural areas often have limited options for recreation or socialization. These options often involve having to budget for an outlay of expenses that is later reimbursed by the employer. How can agencies hiring WI-CPSs assist people that may live on a fixed income plan for these occurrences?

WI-CPS working in a rural area may have to deal with stigma from past episodes of their mental illness. How can they separate themselves from past experiences and be seen as the professional that they are now?

A person that was once viewed by other people (consumers and professionals) as a participant in mental health services is now considered a professional. Other consumers can adopt a negative view of the WI-CPS now that they are working as an employee of the agency. How does someone navigate that change?

People living in rural communities often have limited options for service providers. It may be that you work for the agency that has provided you supports over the years.

How do you provide services to a consumer who sees a provider with whom you have had conflicts?



### **Rural Employer Issues and questions to consider**

- The base of eligible employees for the position of WI-CPS may be limited. Do you hire people who you currently support and how do you negotiate the dual roles of provider and employer?
- How can you assure the WI-CPS that you hire that the position they have been hired for is something they can count on for income? Rural areas often don't have enough job opportunities for someone to find other work to make ends meet.
- Where will the WI-CPS be stationed in the agency to ensure that their interactions with consumers are private and confidential? How can the employer help the WI-CPS feel a part of the team?

## **Preparing Staff for the Inclusion of a Wisconsin Certified Peer Specialist**

When employing WI-CPSs in your agency, it is important to actively prepare existing staff for this change. The WI-CPS has training and experiences and has passed a competency exam that prepares them to work as a peer specialist. Some staff may be uncomfortable with this change. Honoring these feelings and working towards a fact based understanding of the role of the WI-CPSs can be helpful with this. One fear that existing staff throughout Wisconsin have expressed is their concern that the WI-CPS is a cheaper and less educated clinician. The Peer Specialist model is clear that WI-CPSs are not clinicians and should not work outside of their scope of expertise. The role of the WI-CPS is different and not intended to replace solid clinical practice.

Another potential concern for existing staff may be related to stigma and discomfort around working with someone who identifies as having lived experience with mental illness. This may be due to personal or professional experiences or the belief that WI-CPSs will not be held to the same standards as the rest of the team. WI-CPSs are expected to be responsible for their own recovery and accountable to themselves, service recipients, coworkers and supervisors. Stigma may be overcome by working directly with the WI-CPS to help staff gain a new perspective on the value of their role. Once again, honoring the concerns and working with staff to overcome these concerns is effective.

Sharing the Code of Conduct, job description and other educational products with other staff may be helpful in educating them about the role and value the WI-CPS brings to the team. The WI-CPS works with service recipients and staff in a manner that incorporates the policies of the peer specialist program and the agency policies that outline conduct and responsibilities for all staff.

Some additional suggestions:

- Always encourage existing staff to share concerns
- Talk about the unique contribution a Certified Peer Specialist brings
- Clarify roles in the workplace

## **Confidentiality of a Wisconsin Certified Peer Specialist**

*Even though employers are already aware of the legal requirement of confidentiality, the Certified Peer Specialist is a newly created position and with it comes additional issues to be aware of.*

Certified Peer Specialists are employees of an agency who actively work to support service recipients. An identified issue is the records of the WI-CPS who may have been served within the agency where they are now employed. It is essential for employers to seal or protect the records of the WI-CPS once they become employed. This is important for several reasons. It is the employer's obligation to maintain standards for the privacy and confidentiality of records. Employers must demonstrate that other staff of programs may not indulge in natural curiosity about the history of the WI-CPS when the person's records are confidential in nature. Another reason is for the WI-CPSs comfort level in feeling included as part of the staff. When their treatment history is available to all staff it may create a power imbalance that is not productive to the team environment. This is even more of an issue in rural environments in which the employing agency may be the only treatment option in certain communities.

CPSs by definition have the lived experience of mental health issues and other staff may want to know the persons diagnosis or history. The Supervisor of the CPS should not release this type of information but suggest the staff person ask the CPS directly. Choice about sharing this type of information is critical to the successful inclusion of CPSs in an employment environment.

## **Creating a Stigma- Free Work Environment**

### **Fighting Stigma: From Mental Health America Wisconsin<sup>2</sup>**

The workforce includes many individuals with psychiatric disabilities whose disabilities may be stigmatized and misunderstood. Despite the contributions of numerous people who have had, or have, mental illnesses, employers and the public may discourage people who have a mental illness from fulfilling their career goals.

In fact, due in part to stigma and discrimination, the unemployment rate among people with serious and persistent mental illnesses is 90% -- far higher than the 50% unemployment rate among individuals with physical or sensorial disabilities. In other words, only 10% of individuals with persistent mental illnesses who want to work, and are able, are working.

The employment of people with mental illnesses helps employers fill job openings and contributes to society through the return of paid taxes and Social Security and reduced use of government health and disability benefits. Employers who have hired individuals with mental illnesses report that their attendance and punctuality exceed the norm, and that their motivation, work quality, and job tenure is as good as or better than that of other employees.

To find more resources on the employment of those with mental illnesses, visit the SAMHSA ADS Center Web site, which is also the source of the above information. <sup>2</sup> (resource pages)

### **What can employers do?**

Companies that proactively address overall mental health in the workplace can realize significant benefits. Mental health friendly practices can bring greater productivity, reduced insurance costs, and improved retention. They can, in fact, affect the entire culture of the company.

### **How to be pro-active...**

Mental health is one of the most important issues facing employers and employees. Taking and keeping a job has consistently been shown as a key life goal, and the confidence and self-esteem employment provides is a key to emotional wellbeing. A workplace that promotes good mental health achieves more through greater morale and productivity.

The National Mental Health Association/National Council for Community Behavioral Healthcare has created a guide to assist employers in creating a stigma-free workplace. The guide contains eight recommendations and can be found in the 'Attachments' section of this toolkit. <sup>3</sup>

*Create a Stigma-Free Workplace- NMHA/National Council for Community Behavioral Health (please see the attachments section)*

*Stigma and Work-Heather Stuart, PhD (please see the attachments section)*

## **Supervising and Supporting the Wisconsin Certified Peer Specialist**

Supervisors of WI-CPS should be thoroughly knowledgeable with the job role, general Wisconsin job description and Code of Conduct.

- Ideally, the WI-CPS will have a reflective/consultative supervisor with experience in mental health recovery or has worked as a WI-CPS. Someone learning from a professional discipline or role benefits from mentorship from someone trained and experienced in that role.
- Certified Peer Specialists are sometimes described as “in but not of the system.” It is important that supervisors work to provide integration of the WI-CPS in goal planning and team meetings.
- Under the Comprehensive Community Services rule, Certified Peer Specialists require supervision by a qualified mental health professional which is explained in the Wisconsin Department of Health Services DHS 36.10

### **Best Practices in Employment of Peer Specialists\*:**

1. Hire people who are qualified to do the job—no tokenism; lived experience by itself is not enough. Peer specialists need relevant work experience and/or training.
3. Develop a clear job description and provide detailed information about essential functions of the job, job expectations and requirements. Revisit the job description from time to time to ensure that it is up to date.
4. Apply the principles of universal design when you develop human resources policies that are flexible enough to create an accepting, adaptable program culture that works for everyone.
5. Provide accommodations through a standardized disability policy that applies to everyone. Inform all of your staff about the process for requesting accommodations.
6. Provide competency-based training and supervision and remember that changing practice (or any habitual behavior pattern) is much more difficult than teaching an inexperienced person the right way from the beginning
8. Use a qualified and knowledgeable supervisor.
9. Enforce requirements through existing and standardized feedback, supervision and performance evaluation mechanisms.

*\*excerpted from NJPRA Summary November 2010 (references and complete document in attachment section)*

The WI-CPS does not require ‘special treatment’ but equitable treatment when medical or personal situations arise.

There are no indicators that WI-CPS require more ‘sick days’ or take above average time off for medical reasons (based on surveys in Wisconsin).

Employers need to plan, as with any employee, for who will take over the responsibilities of the WI-CPS should they need to take time off.

Considerations:

- Is there more than one WI-CPS on staff?
- How will the consumer's needs be met if the WI-CPS has to take an extended leave?
- Can the employer partner with another agency/organization to provide v services during their WI-CPS's leave of absence?
- Does the employer have a plan in place for working with the WI-CPS to transition back into the workplace once they feel well enough to return?

Keeping the lines of communication open and discussing these possibilities can be a positive, effective way to plan for continuation of services.

*Practices in Peer Specialist Supervision and Employment- New Jersey Psychiatric Rehabilitation Association (NJPRA) November 17-18, 2010 Conference (see attachment section)*

*Reciprocal Supervision: How Peer Specialists and Their Supervisors Can Work Together for Lasting Recovery Best Practices in Employment of Peer Specialist (see attachment section)*

*We've Hired Peer Specialists-Now What? Common Questions and Concerns in Employing Persons in Recovery – Janis Tondora, Psy.D., Yale University (see attachment section)*

## **Recertification Requirements of Wisconsin Certified Peer Specialist**

Wisconsin Peer Specialist certification is valid for two years. In this two year period, 20 total hours of Continuing Education (CEH) and/or Continuing Education Units (CEU) must be obtained to qualify for recertification.

The required areas of education are:

1. Cultural Competence – The ability to interact effectively with people of different cultures. Cultural competence is the ability to understand behavior from the standpoint of the members of a culture and to behave in a way that would be understood by the members of the culture in the intended way. Cultural competence involves understanding all aspects of a culture, particularly the social structure, the values and beliefs of the people and the way things are assumed to be done.
2. Ethics and Boundaries – To acquire the skills to be able to understand and maintain confidentiality and appropriate boundaries. To recognize when to seek guidance or consultation. (These could include the Health Insurance Portability and Accountability Act (HIPAA) training and ethical decision making models.)
3. Trauma Informed Care – Trauma-informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives.

4. Peer Specialist Specific – To increase the skills in the role of a Peer Specialist in working with participants. These might Wellness Recovery Action Plans (WRAP), Recovery, Person-Centered Planning, Motivational Interviewing, etc.
5. Substance Use Disorder – To acquire knowledge and increase skills in the ability to engage people with a history of substance use disorder as well as mental health and recognize the role that substance use disorder has played in their lives.

There must be at least 1.5 training hours in each of the four required categories. Certified Peer Specialists may choose any other continuing education courses they wish related to the Peer Specialist field and must have a minimum of 20 hours of continuing education based on the Wisconsin Peer Specialist Core Training Competencies.

Certified Peer Specialists are solely responsible for maintaining their Continuing Education Hours and providing documentation of completion to the University of Wisconsin-Milwaukee (UWM).

## **Living Wages and Benefits/Work-Incentive Counseling**

The Certified Peer Specialist (WI-CPS) is a professional position. It was created as a career path and employment initiative.

The national average for a starting wage (2012) for a WI-CPS is \$13.50 per hour. Certified Peer Specialists can work part-time or full-time if it is agreeable to both the employer and the WI-CPS to meet the needs of the organization/agency. It is important that the WI-CPS remain healthy and in recovery in order to work effectively with Peers.

Employees (WI-CPS) are advised to request ongoing Work Incentives Benefits Counseling in order to have the information needed for making informed choices about work and earnings. If a WI-CPS is going to work full-time the employer is encouraged to make information available to the WI-CPS's regarding transitioning from SSI/SSDI to employer based benefits, if available, and be aware of the Work Incentive Programs provided to individuals with disabilities.

## **ADA Job Accommodations**

A reasonable accommodation for workers with a disability does not have to be a complicated process. The Office of Disability Employment Policy (ODEP) provides *The Employers' Practical Guide to Reasonable Accommodation under the Americans with Disabilities Act*. The complete guide is part of this Toolkits attachments and drive.

Section III provides an explanation for reasonable accommodations for employees.

One of the key non-discrimination requirements of Title I of the ADA is the obligation to provide reasonable accommodation for employees with disabilities. This section provides information about what policies and procedures might be useful, how to recognize and handle accommodation requests, how to determine effective accommodations and what types of accommodations might be reasonable.

A reasonable accommodation is a modification or adjustment to a job, the work environment, or the way things usually are done that enables a qualified individual with a disability to enjoy an equal employment opportunity. An equal employment opportunity means an opportunity to attain the same level of performance or to enjoy equal benefits and privileges of employment as are available to an average similarly-situated employee without a disability.

The ADA requires reasonable accommodation in three aspects of employment:

- 1) To ensure equal opportunity in the application process
- 2) To enable a qualified individual with a disability to perform the essential functions of a job
- 3) To enable an employee with a disability to enjoy equal benefits and privileges of employment.
  - Examples of reasonable accommodations include making existing facilities accessible; job restructuring; part-time or modified work schedules; acquiring or modifying equipment; changing tests, training materials, or policies; providing qualified readers or interpreters; and reassignment to a vacant position. Keeping a clear line of communication with employees regarding the accommodation request and how it will be reviewed and outcomes provides a professional and supportive workplace.  
(*Employers' Practical Guide to Reasonable Accommodation Under the Americans with Disabilities Act-Job Accommodation Network (JAN)* please see the attachments section)

***"See the ability not the disability"***

## **Funding/Billing for Wisconsin Certified Peer Specialists**

When part of a State mental health benefit, the Certified Peer Specialist Services can be billed under several areas for Medical Assistance (MA). A few examples include:

- Assisting consumers in the development of a recovery action plan as part of goal planning
- Specific skill training for the consumer including the areas of communication, interpersonal skills, problem solving, assertiveness, conflict resolution
- Working with consumers in activities related to pre-employment preparation; skills assessment, anxiety reduction, education about workplace etiquette, arranging transportation
- Offering effective recovery-based services
- Assisting consumers in finding self-help groups
- Assisting consumers in obtaining services that suit that individual's recovery needs
- Teaching problem solving techniques
- Teaching consumers how to identify and combat negative self-talk and how to identify and overcome fears
- Assisting consumers in building social skills in the community that will enhance integration opportunities
- Lending their unique insight into mental illness and what makes recovery possible
- Attending treatment team and crisis plan development meetings to promote consumer's use of self-directed recovery tools
- Informing consumers about community and natural supports and how to utilize these in the recovery process
- Assisting consumers in developing empowerment skills through self-advocacy and stigma-busting activities

*(Please see the attachment section for the Wisconsin Forward Health 2012 update and service billing information.)*



## Organizational Self-Assessment Tool (Survey)

Is your organization recovery-oriented? Are you ready to implement a Wisconsin Certified Peer Specialist into your program of services? What can you do to improve your organizations recovery-oriented mental health services culture and services?

This survey tool contains 25 items. It uses a four-point rating scale. To complete the survey, the organization/agency should select staff from administrative positions, clinical and other supervisors, and directly from existing staff. Staff selected should include individuals who are most knowledgeable about how mental health services are delivered at the agency in specific programs. It is important to collect survey information from staff in each of your programs within the agency.

*A staff person should be designated to take the lead in collecting, scoring, and interpreting the results and in applying findings as part of a recovery-oriented services and a Wisconsin Certified Peer Specialist implementation plan.*

### **Agencies may collect information by the following methods:**

- **Manual Collection:** The survey and instructions may be distributed to staff members in hard copy to complete. Data from each survey may be entered into a spreadsheet application.
- **Web-based:** The survey may be loaded onto a web-based platform using survey software applications such as SurveyMonkey™. The survey and instructions may then be forwarded to staff members via e-mail and accessed through a link in the e-mail message. This opportunity may provide a more streamlined data collection process.

In addition to the Assessment Survey, agencies may conduct staff focus groups to gather more detailed information about how services are implemented. The focus groups may discuss specific areas identified in the Assessment Survey and target specific programs and staff. The discussion can help provide a deeper understanding of staff perspectives and issues that affect the implementation of a Wisconsin Certified Peers Specialist at the agency. The discussion can also help foster collaboration among staff and assist them in developing strategies for mental health program improvement.

The survey tool template that is included can be modified and/or expanded to include any additional information you may wish to gather regarding new programs and services that may include Wisconsin Certified Peer Specialists.

These types of organizational surveys can be done on a quarterly basis for program review.

Health organizational culture in Mental Health Recovery is a crucial component in the success of a new or existing program. Some of the known successes are:

- Organizations/Agencies often become better places to work
- Programs show continued improved outcomes
- Employee retention grows and there is a greater 'ownership' in the workplace
- Synergy is created and teams work more effectively
- Service recipients/consumers receive higher quality services
- Community collaboration and partnerships improves

**Please answer the following statements to assist in determining your organizations readiness for the integration of a WI Certified Peer Specialist.**

All of the items are scored on a four-point scale: 1 = Strongly Disagree, 2 = Mostly Disagree, 3 = Mostly Agree and 4 = Strongly Agree. \*

	Overall Agency Readiness	1	2	3	4
1.	The agency has a comprehensive program to promote recovery-oriented knowledge, attitudes and skills in its workforce.				
2.	The agency staff implements culturally sensitive service plans that consider the impact of the culture on the person's experience of mental illness.				
3.	The agency provides wellness education and support to service recipients.				
4.	Agency staff uses person-centered planning that includes the service recipient in all aspects of their goal planning.				
5.	The agency provides service recipients with information regarding peer run services, support groups, drop-in centers, respite center services and other programs available in the service area.				
6.	Agency staff uses person-first language in all written and verbal communication.				
7.	Agency staff works from a strength based approach with mental health service recipients.				
8.	Agency staff is knowledgeable about SAMHSA's Eight Dimensions of Wellness and their current Mental Health Wellness Initiative.				
9.	Agency staff is knowledgeable that Peer Specialist Services are an evidence-based practice.				
10.	The agency provides ongoing education opportunities to staff regarding whole health care and holistic approach to recovery.				
	Individual Staff Self-Assessment (all staff members) Please rate the following statements about how your agency currently reflects its readiness to incorporate a WI-Certified Peer Specialist (WI-CPS) as a staff member.	1	2	3	4
11.	I am knowledgeable about the Wisconsin General Job Description for Certified Peer Specialists.				
12.	It is understood that a WI-CPS is not a clinician, but will bring the unique value of lived experience and important skills and insights to the workplace.				

Individual Staff Self-Assessment (all staff members)		1	2	3	4
Continued from previous page...					
13.	I recognize the value that a WI-CPS can bring to the effective services delivered by my agency.				
14.	I am knowledgeable about the guiding principles of recovery.				
15.	I recognize that WI-CPS have a distinct discipline, ethical guidelines, training and certification requirements and detailed scope of services.				
16.	I understand that WI-CPSs are not an ancillary position but are an integral part of a service recipient's recovery process.				
17.	My agency has regularly scheduled staff meetings and evaluations for employees in order to give and provide feedback.				
18.	I recognize that the lived-experience of the WI-CPS in mental health recovery is a valuable tool for working with service recipients on their personal recovery.				
19.	I am able view a person with lived experience as a valued member of the agency team.				
20.	As a staff person I would be willing to assist in the integration of a WI-CPS in my agency.				
Current and Potential Supervisors of WI-Certified Peer Specialists please rate the following...		1	2	3	4
21.	I am willing to create opportunities for WI-CPSs to use their lived experience to increase awareness and understanding of the mental health recovery process for other team members.				
22.	I see myself as a champion of WI-CPSs and Peer Support within my agency.				
23.	I am prepared to respond in a supportive way to personal wellness concerns of all supervisees, including WI-CPSs.				
24.	My agency is willing to support a flexible work schedule to allow time for WI-CPSs to obtain Continuing Education Hours to maintain their certification.				
25.	I recognize the importance of confidentiality of documents and files of WI-CPSs that may have received services from my agency before becoming an employee.				

\*adapted from the Louis de la Parte Florida Mental Health Institute SAPT Version 2.0 template and the North Carolina Springboard Learning Portal, "Supervising Peer Support Specialists: Organizational Readiness Inventory template.

# Resources

## Wisconsin

**The Wisconsin Department of Health Services Bureau of Prevention Treatment and Recovery** -The Bureau of Mental Health and Substance Abuse Services' mission is to support and improve the quality and effectiveness of mental health and substance abuse services in order to create a recovery-focused system for the people of Wisconsin.

The Division of Mental Health and Substance Abuse Services (DMHSAS) manages programs that provide community mental health and substance abuse services. It also administers the State's institutional programs for persons whose mental needs or developmental disabilities cannot be met in a community setting.

The Division also oversees the WI Certified Peer Specialist Program.

Kenya Bright, Section Chief

1 W. Wilson St.

Madison, WI 53703

Telephone (DMHSAS Main line): (608) 266-2717

<http://www.dhs.wisconsin.gov/aboutdhs/DMHSAS/index.htm>

### **The Wisconsin Certified Peer Specialist Employment Initiative**

Access to Independence in Madison, WI is contracted to be the central point of contact for the WI Certified Peer Specialist Program and houses the Program Coordinator. Questions regarding becoming A Certified Peer Specialist, Certification Exam Process, Recertification and general program information should be directed to:

Access to Independence

3810 Milwaukee Street

Madison, WI 53714

608-242-8484 ext. 224

[www.wicps.org](http://www.wicps.org)

### **Mental Health America Wisconsin**

Mental Health America of Wisconsin (MHA) is an affiliate of the nation's largest and oldest community-based network dedicated to helping all Americans live mentally healthier lives. MHA touches the lives of millions by:

- Advocating for changes in policy
- Educating the public and providing critical information
- Delivering urgently needed programs and services

MHA is a nonprofit organization dedicated to helping ALL people live mentally healthier lives. We represent a growing movement of Americans who promote mental wellness for the health and well-being of the nation - every day and in times of crisis.

Mental Health America of Wisconsin

600 W. Virginia St, Suite 502  
Milwaukee, WI 53204  
(414) 276-3122 or (866) 948-6483 (toll free)  
Madison Office  
Mental Health America of Wisconsin - Office of Public Policy  
133 S. Butler, Room 330  
Madison, WI 53703 (608) 250-4368  
[www.mhawisconsin.org](http://www.mhawisconsin.org)

### **NAMI Wisconsin**

The mission of NAMI Wisconsin is to improve the quality of life of people affected by mental illnesses and to promote recovery. Download the NAMI Wisconsin 2012 Fact Book on their website.

NAMI Wisconsin  
4233 West Beltline Highway  
Madison, WI 53711  
(608) 268-6000  
(800) 236-2988  
[www.namiwisconsin.org](http://www.namiwisconsin.org)

### **Wisconsin United For Mental Health**

Wisconsin United for Mental Health (WUMH) is a coalition of Wisconsin citizens who share a dream of a society in which people are not labeled or judged as lesser or unworthy on the basis of health diagnosis. The coalition is committed to working in unity for the purpose of eliminating the stigma of mental illnesses. WUMH recognizes the strength of a small group of committed citizens and works primarily to identify and develop opportunities to teach people that mental illnesses are real, common and treatable.

Mental Health America of Wisconsin  
734 N. 4th Street, Suite 200  
Milwaukee, WI 53203-2102  
Phone: 866-WIUNITED (948-6483)  
[www.wimentalhealth.org](http://www.wimentalhealth.org)

Mental Health at Work: The Competitive Advantage  
A training resource for managing mental health in the workplace  
It's available on DVD and at [www.wimentalhealth.org](http://www.wimentalhealth.org)

### **Employment Resources, Inc. (ERI)**

Employment Resources, Inc. (ERI) is a private, non-profit organization located in Madison, Wisconsin. Since 1990 our mission has been to increase employment opportunities for people with disabilities. ERI provides employment and benefits counseling, assistive technology, and community outreach services to people with disabilities who are considering or pursuing employment. ERI also offers statewide consultation, training and technical assistance to

employers, human service professionals, disability advocates, government agencies and the public regarding disability and employment issues.

4126 Lien Road, Ste. 104  
Madison, WI 53704-3605  
Phone: 608-246-3444  
Toll-free: 1-855-401-8549  
[www.eri-wi.org](http://www.eri-wi.org)

## **National Resources**

### **The Job Accommodation Network (JAN)**

The Job Accommodation Network (JAN) is the leading source of free, expert, and confidential guidance on workplace accommodations and disability employment issues. Working toward practical solutions that benefit both employer and employee, JAN helps people with disabilities enhance their employability, and shows employers how to capitalize on the value and talent that people with disabilities add to the workplace.

Toll-Free: (800)526-7234 (Voice)  
(877)781-9403 (TTY)

<http://askjan.org>

### **NAMI STAR**

The STAR Center provides Support, Technical Assistance and Resources to assist consumer-operated and consumer-supporter programs in meeting the needs of under-served populations. Specifically, the STAR Center's focus areas are cultural competence and diversity in the context of mental health recovery and consumer self-help and self-empowerment.

STAR Center  
3803 N. Fairfax Dr., Suite 100  
Arlington, VA 22203  
star@nami.org  
Toll-Free: (866) 537-STAR (7827)  
[www.consumerstar.org](http://www.consumerstar.org)

**North Carolina “Supervising Peer Support Specialists”** is a free three hour training that any person can access by joining the group. It is specific to North Carolina but the majority of the information is general to supervising CPSs.

Please go to: <http://bhrp.sowo.unc.edu/user/register> to sign up for an account and then choose the training portal by title.

**SAMHSA- Substance Abuse and Mental Health Services Administration**

1 Choke Cherry Rd  
Rockville, MD 20857  
Phone: 1-877-SAMHSA-7 (877-726-4727)

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

<http://beta.samhsa.gov/about-us>

**SAMHSA-ADS Center**

[www.promoteacceptance.samhsa.gov](http://www.promoteacceptance.samhsa.gov)

**SAMHSA-Recovery to Practice**

<http://www.samhsa.gov/recoverytopractice/>

**SAMHSA GAINS Center for Justice-Involved Consumers**

[www.gainscenter.samhsa.gov](http://www.gainscenter.samhsa.gov)

Phone: 800.311.4246

**SAMHSA. (2005). Building a Foundation for Recovery: A Community Education Guide on Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce. DHHS Pub. No. (SMA) 05-8089.**

[www.samhsa.gov](http://www.samhsa.gov)

**Wellness Recovery Action Plan (WRAP™)**

The Wellness Recovery Action Plan®, or WRAP™, is an evidence-based system that is used world-wide by people who are dealing with mental health and other kinds of health challenges, and by people who want to attain the highest possible level of wellness. It was developed by a group of people who have a lived experience of mental health difficulties; people who were searching for ways to resolve issues that had been troubling them for a long time. WRAP® involves listing your personal resources, your Wellness Tools, and then using those resources to develop Action Plans to use in specific situations which are determined by you. WRAP® is adaptable to any situation. WRAP® also includes a Crisis Plan or Advance Directive.

[www.mentalhealthrecovery.com](http://www.mentalhealthrecovery.com)

[www.copelandcenter.com](http://www.copelandcenter.com)

**What Helps and What Hurts when Supervising Peer Specialists-Magellan Health Services**

<http://www.magellanhealth.com/training/peersupport/magellanmodule7/wha06/01wha06.htm>

## References

**<sup>1</sup> SAMHSA- Reciprocal Supervision: How Peer Specialists and Their Supervisors Can Work Together for Lasting Recovery**

M. C. Violet Taylor

Published in Recovery to Practice April 5, 2012

<http://www.dsgonline.com/rtp/wh/2012/2012.04.05/WH.2012.04.05.html>

**<sup>2</sup> SAMHSA-ADS Center**

[www.promoteacceptance.samhsa.gov](http://www.promoteacceptance.samhsa.gov)

**<sup>3</sup> National Mental Health Association/National Council for Community Behavioral Healthcare**

[www.thenationalcouncil.org](http://www.thenationalcouncil.org)

**<sup>4</sup> Practices in Peer Specialist Supervision and Employment- New Jersey Psychiatric Rehabilitation Association (NJPRA) November 17-18, 2010 Conference**



## ATTACHMENTS

- Technical Assistance Request Form (A1)
- Create a Stigma-Free Workplace- NMHA/National Council for Community Behavioral Health (A2)
- Stigma and Work-Heather Stuart, PhD (A3)
- Practices in Peer Specialist Supervision and Employment- New Jersey Psychiatric Rehabilitation Association (NJPRA) November 17-18, 2010 Conference (A4)
- Reciprocal Supervision: How Peer Specialists and Their Supervisors Can Work Together for Lasting Recovery Best Practices in Employment of Peer Specialist (A5)
- Employers' Practical Guide to Reasonable Accommodation Under the Americans with Disabilities Act-Job Accommodation Network (JAN) (A6)
- Forward Health Wisconsin Update 2012 (A7)
- Overview of Community Recovery Services and Comprehensive Community Services (A8)
- SAMHSA's Eight Dimensions of Wellness (A9)
- We've Hired Peer Specialists-Now What? Common Questions and Concerns in Employing Persons in Recovery – Janis Tondora, Psy.D., Yale University (A10)

## Technical Assistance Request Form (A1)



**Peer Specialists**  
*Igniting Recovery*

### WI-Certified Peer Specialist Employer Technical Assistance Request Form

Please fill out this form to request assistance in the hiring, integration and support of WI Certified Peer Specialists (WI-CPS) or if you are a current employer seeking assistance with WI-CPS support topics.

Date Services Requested: \_\_\_\_\_

Organization/County/Agency: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Website: \_\_\_\_\_ Contact Person: \_\_\_\_\_

I am requesting technical assistance in the following areas (check all that apply):

- Hiring/developing a job posting
- Organizational Readiness Survey for employment of a WI-CPS
- Preparing staff for the inclusion of a WI-CPS
- The WI-CPS Employer Toolkit
- General information about the WI-CPS Employment Initiative
- Other (please explain): \_\_\_\_\_

Do you currently employ Wisconsin Certified Peer Specialists?  YES  NO

If 'Yes', how many: \_\_\_\_\_ If 'No', when are you looking to hire? \_\_\_\_\_

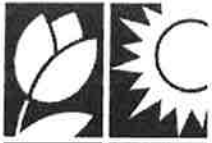
In what programs will or are the WI-CPS providing services? \_\_\_\_\_

What type of billing do you use? (i.e. MA): \_\_\_\_\_

Please submit the completed form by mail, email or FAX to:

Access to Independence, Inc.  
Att. Alice F. Pauser  
3810 Milwaukee St.  
Madison, WI 53714  
FAX: 608-242-0383  
[alicep@accesstoind.org](mailto:alicep@accesstoind.org)  
Phone: 608-242-8484 ext. 224 or 800-362-9877  
TTY: 608-242-8485  
[www.wicps.org](http://www.wicps.org)

**Create a Stigma-Free Workplace- NMHA/National  
Council for Community Behavioral Health (A2)**



## Create a Stigma-Free Workplace

**I**F YOU WERE TO ASK PEOPLE WHO HAVE A MENTAL ILLNESS, “WHAT’S THE WORST PART OF HAVING A DISORDER?” MANY WILL SAY, “THE STIGMA.” FEELINGS OF SHAME, CONCERNS ABOUT JOB SECURITY, AND FEAR OF REJECTION BY COLLEAGUES ARE OFTEN OVERWHELMING AND INTERFERE WITH PRODUCTIVITY. AND THESE ISSUES OFTEN DISCOURAGE MANY FROM SEEKING THE HELP THEY NEED.

Many innovative employers have learned that addressing their employees’ mental health needs makes good economic sense. They also recognize that they play an essential role in their employees’ mental health not only by offering adequate insurance coverage for mental health care, but also by creating an environment that supports people who need help.

To help support employers, NMHA recommends the following strategies for creating a stigma-free workplace:

- ◆ **Educate:** Employees at all levels of the organization need to learn about mental illnesses, stress and wellness, as well as the signs and symptoms of mental health disorders.

It is equally important to educate staff about the benefits and services their employer provides and how to access them. Supervisors should receive training to learn how to intervene appropriately if they think an employee may have a mental health problem.

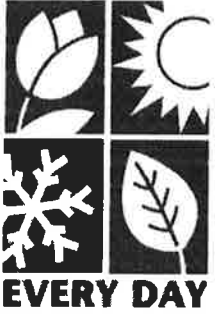
- ◆ **Encourage dialogue:** Organizations that can talk candidly about mental health and stress getting appropriate help set a positive and supportive tone among employees. Create a safe environment in which staff members are encouraged to talk about stress, workloads, family commitments and other issues.

- ◆ **Send the message that mental illnesses are real, common and treatable:** Many people mistakenly believe that mental illnesses are permanent and untreatable. In fact, with access to appropriate treatment, the vast majority of people with mental illness see significant improvement in their disorders and lead stable, productive lives.

- ◆ **Discourage stigmatizing language:** Stigma begins with hurtful labels such as “crazy,” “loony” or “nuts.” Discourage staff members at all levels from using such language and encourage “people-first” language, which puts a human face on mental illness (for example, say “a person with schizophrenia” as opposed to using the dehumanizing term “a schizophrenic”).

- ◆ **Invest in mental health benefits:** Actions do speak louder than words, so it’s essential to invest in mental health benefits, including appropriate insurance coverage for treatment, and prevention and educational programs. Be sure to confirm that the treatment and services your organization has paid for are indeed available through an adequate network of providers.

## Mental Health MATTERS



- ◆ **Try using the Internet:** Some employers are making use of Internet and Intranet technology to provide mental health and benefit information to their employees. Some provide useful links from their sites to provider directories and wellness information, and also offer toll-free information numbers. Feel free to link to the NMHA Web site at [www.nmha.org](http://www.nmha.org), or to your local Mental Health Association site.
- ◆ **Help facilitate a healthy transition back to work:** Some people may need time off work for treatment, and employers need to ensure a healthy transition back to the office. Management should help create an environment in which people feel welcomed and encouraged to ask for the help they need—and, above all, not judged. Employers should also have a policy in place to accommodate the needs of staff members who have “standing appointments” for mental health treatment.
- ◆ **Seek consultation:** If your health or mental health administrator includes an Employee Assistance Program (EAP), its staff may be helpful in implementing all these efforts. In addition, your local Mental Health Association shares your goals of educating staff, eliminating stigma and improving emotional well-being. Many provide workplace education and screenings for mental illnesses. Contact your local Mental Health Association to discuss the possibilities of a partnership.

To learn more, contact your local Mental Health Association or the National Mental Health Association at 800-969-NMHA (6642) or [www.nmha.org](http://www.nmha.org)

**Stigma and Work-Heather Stuart, PhD (A3)**

# STIGMA AND WORK



DISCUSSION PAPER

*Heather Stuart, PhD*

Community Health and Epidemiology, Queen's University



## ABSTRACT

*This paper addresses what is known about workplace stigma and employment inequity for people with mental and emotional problems. For people with serious mental disorders, studies show profound consequences of stigma, including diminished employability, lack of career advancement and poor quality of working life. People with serious mental illnesses are more likely to be unemployed or to be underemployed in inferior positions that are incommensurate with their skills or training. If they return to work following an illness, they often face hostility and reduced responsibilities. The result may be self-stigma and increased disability. Little is yet known about how workplace stigma affects those with less disabling psychological or emotional problems, even though these are likely to be more prevalent in workplace settings. Despite the heavy burden posed by poor mental health in the workplace, there is no regular source of population data relating to workplace stigma, and no evidence base to support the development of best-practice solutions for workplace anti-stigma programs. Suggestions for research are made in light of these gaps.*

### **Purpose**

This paper was commissioned by the Working Group mandated by the Canadian Institute of Population and Public Health and the Institute of Neurosciences, Mental Health and Addictions of the Canadian Institutes of Health Research to suggest

priority areas for stigma research as part of a national research agenda on mental health and the workplace.

### **Stigma Defined**

In ancient Greece, citizens pricked marks on their slaves using a pointed instrument,

---

The author would like to acknowledge the assistance of Michelle Koller, Research Associate, Stigma Research Program, Queen's University in collecting the literature used in this manuscript.



both to demonstrate ownership and to signify that such individuals were unfit for citizenship. The ancient Greek word for prick is stig, and the resulting mark, a stigma. In modern times, stigma is understood as an invisible mark that signifies social disapproval and rejection (Goffman 1963; Dovidio et al. 2000; Falk 2001). Stigma is deeply discrediting and isolating, and it causes feelings of guilt, shame, inferiority and a wish for concealment (Goffman 1963).

### **Caveat**

Stigma literature relating to mental health focuses almost exclusively on mental disorders – illnesses that meet certain clinical thresholds for severity and duration, or mental health conditions that have been of sufficient severity to require psychiatric treatment. In this context, stigma has been variously understood as a consequence of the visible signs or symptoms of a disorder; a result of having received a psychiatric label, regardless of whether visible signs or symptoms are present; or as a consequence of having received psychiatric treatment, particularly if the locus of care was a psychiatric hospital or if treatment was legally mandated. While Canadians express stigmatized views of people with serious mental illnesses such as schizophrenia (Stip et al. 2001; Stuart and Arboleda-Flórez 2001; Thompson et al. 2002; Stuart 2003a; Stuart 2003b), the literature does little to examine the extent to which stigma is a consequence of other dimensions of mental health, such as less serious psychological or emotional problems like substance misuse or depression. Consequently, the remaining discussion concentrates on the stigma of severe mental illness and refers to information on other mental disorders when it is available.

### **General Consequences of Stigma**

“Stigma is an ugly word, with ugly consequences” (Leete 1992: 19), and mental illnesses confer the “ultimate stigma” (Falk 2001; Smith 2002). Goffman (1963) once said that people with mental disorders start out with rights and relationships, but end up with little of either. Stigma adds a dimension of suffering to the primary illness – a second condition that may be more devastating, life-limiting and long-lasting than the first (Schulze and Angermeyer 2003).

Most people with a mental illness are treated in the community, where stigmatizing attitudes can impede recovery and promote disability. Stigma hinders social integration, the performance of social roles, timely access to treatment and quality of life. Other consequences are unemployment, lack of housing, diminished self-esteem and weak social support (Link et al. 1991; Wolff 1997; Markowitz 1998; Wahl 1999a; Stip et al. 2001; Prince and Prince 2002). A key consequence of stigma is that we harbour lower expectations for people with a mental illness and easily accept a quality of life for them that we would not accept for ourselves (Jones 2001).

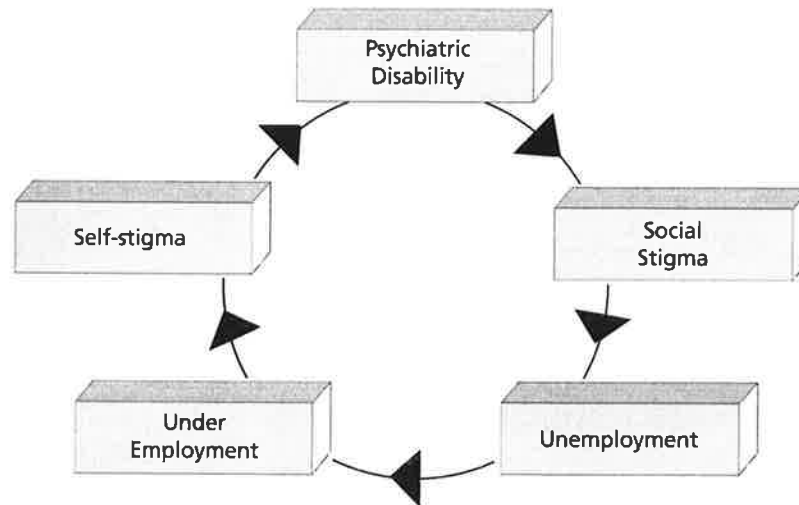
Stigma, and the expectation of stigma, can also produce serious disruptions in family relationships and reduce normal interactions (Wahl and Harman 1989). For families, stigma means fear, loss, lowered family esteem, shame, secrecy, distrust, anger, inability to cope, hopelessness and helplessness (Gullekson 1992). Families are often directly blamed for causing the illness or criticized for harbouring persons who are potentially harmful or offensive (Lefley 1992).

Stigma also surrounds mental health professionals and services. Sartorius (2004) notes that mental health professionals are

---

**Figure 1. Stigma and Employment Inequity**


---



themselves frequently portrayed as mentally abnormal, corrupt or evil. Psychiatric treatments, which are generally thought to be ineffective or iatrogenic, are approached with profound suspicion and often monitored with much more than the usual zeal. Mental hospitals disgust and horrify, and citizens actively fight to exclude treatment and residential facilities from their neighbourhoods. Stigma also contributes to the persistent under-funding of services and research. In times of economic restraint, the easiest budget to cut is the mental health budget because it rarely results in a public outcry. When there is new money, it goes to groups that are more publicly appealing: children with life-threatening diseases, cancer patients or those with heart disease. Consequently, disciplines related to mental health are less attractive as career options (Sartorius 2004; Kendell 2004).

The consequences of stigma are so pervasive and profound, the World Health Organization and the World Psychiatric Association have identified stigma related to mental illness as the most important challenge facing the mental health field

today (WHO 2001; Sartorius 2004).

### Stigma and Work

No single activity conveys a sense of self more so than work. Work influences how and where one lives, it promotes social contact and social support, and it confers title and social identity. "What do you do?" is one of the first questions asked in any new social relationship. Mental health problems predict unemployment and reduced career goals, and the resulting economic hardship can disadvantage physical and emotional health, quality of life, community participation and recovery (Wahl 1999b). To be excluded from meaningful work not only creates material deprivation; it also erodes self-confidence and results in isolation, alienation and despair. Lack of adequate employment is a key risk factor for mental health problems ranging from mild psychosocial stress to serious depression and suicide (Kates et al. 1990). Figure 1 depicts this as a cycle of unfair and prejudicial attitudes leading to discriminatory employment practices, self-stigma and increased psychiatric disability.

### Stigma and Unemployment

Employment discrimination occurs when someone is denied a job because of their psychiatric status without regard to their qualifications or capabilities; and it is illegal (Wahl 1999b). The Canadian Human Rights Act stipulates that employers must take appropriate steps to eliminate discrimination against employees and prospective employees. Short of undue hardship, employers must accommodate disabled people. In addition, Canada's Employment Equity Act is aimed at improving the representation of people with disabilities in the workforce (Canadian Human Rights Commission 2003).

Most people with a mental illness are both willing and able to work (Macias et al. 2001). Yet their unemployment rates remain scandalously high. Most studies report unemployment rates between 80% and 90% among severely mentally ill patients (Crowther et al. 2001; Dalgin and Gilbride 2003; Drake et al. 1998; Krupa et al. 2003; McQuilken et al. 2003). Those with an affective disorder have better employment rates than those with alcoholism or schizophrenia (Manning and White 1995).

**Table 1: Association Between Unemployment and Psychiatric Disorder\***

Disorder	Odds Ratios for Unemployment
Schizophrenia	4.98
Mania	4.98
Major depression	2.10
Dysthymia	1.69
Phobia	1.54
Panic disorder	2.35
Obsessive compulsive disorder	1.86
Antisocial personality disorder	5.89

\* Adapted from Thompson and Bland (1995).

Data from Edmonton (Tables 1 and 2) show how employment rates vary by diagnostic group in a Canadian sample (Bland et al. 1988). This study also showed that those who were unemployed were twice as likely to report sub-clinical psychological symptoms in the two weeks before the interview, and four times more likely to have previously attempted suicide. This confirms that employment barriers exist across a wide range of mental health and emotional problems.

With figures such as these, it is not surprising that people with mental illnesses

**Table 2: Lifetime Prevalence of Psychiatric Disorders in the Employed and Unemployed in Edmonton, Canada\***

Prevalence			Odds Ratio
	Employed	Unemployed	
Substance use disorder	22.1%	45.9%	3.0
Schizophrenia	0.5	1.5	3.0
Affective disorders	8.8	15.5	1.9
Anxiety/somatoform disorders	12.1	14.3	1.2
Anorexia	--	0.7	15.6*
Antisocial personality disorder	2.8	15.1	6.2
Cognitive impairment	0.3	0.9	2.7
Any disorder	34.8	59.5	2.8

\* Adapted from Bland et al. (1988).

\* Unstable due to small numbers in sample. Results are weighted.

identify employment discrimination among their most frequent stigma experiences. For example, respondents to a consumer survey conducted by the Canadian Mental Health Association found that social and family life (84%), employment (78%) and housing (48%) were the three areas most affected by stigma (Canadian Mental Health Association, Ontario Division 1994).

In a survey of 74 people with schizophrenia receiving outpatient care in Maryland, all but one reported a recent stigma experience. The most commonly identified source of stigma were people in the community (61%), followed by employers and supervisors (36%) and then mental health caregivers (20%) (Dickerson et al. 2002). In a survey of 1,150 primary care patients in Minnesota, 67% of those with a history of depression and 58% of those with a prior psychiatric visit expected to experience employment-related stigma that would make it more difficult for them to find a job – twice the proportion of those with medical disabilities such as diabetes or hypertension. In addition, women were four times more likely to express employment concerns (Roeloffs et al. 2003). These findings suggest that women who are mentally ill may be doubly disadvantaged in the workplace and that other socio-demographic factors (such as age or ethnicity) may interact with the stigma of mental illness to cause a double disadvantage.

US studies show that employers are reluctant to hire someone with a psychiatric history. In a random sample of businesses, approximately half of the employers surveyed expressed discomfort at hiring someone with a previous mental hospitalization and 70% expressed discomfort at hiring someone who was on anti-psychotic medication. Forty-four percent would be

uncomfortable hiring someone who was in treatment for depression, and 69% would be uncomfortable hiring someone with a history of substance abuse (Scheid 1999). Similarly, a survey of 1,426 restaurant owners showed that while almost half had hired a physically handicapped person, only 29% had hired a mentally disabled person (Long and Runch 1983). Almost a quarter of US employers surveyed would dismiss someone for a previously undeclared mental illness, and half would rarely employ someone with a mental illness (Manning and White 1995). Approximately one in three mental health consumers in the United States has been turned down for a job for which they were qualified once their mental health problems were disclosed. For one in five, even attempts to contribute to volunteer jobs were thwarted. This was true for volunteering both inside the mental health system (20%) and outside it (26%). In some cases, job offers were withdrawn once a psychiatric history was revealed. Even when successful in obtaining a job, a quarter noted that co-workers and supervisors were unsupportive once their psychiatric status was known (Wahl 1999a; Wahl 1999b).

A psychiatric diagnosis can also undermine career advancement. In the United Kingdom, for example, 58% of employers would never hire someone with a diagnosis of depression for an executive position, compared to only 5% for a clerical position. Employers associated depression with impaired performance and sick time, more so than chronic physical conditions, suggesting that psychological causes for sick time are less credible than physical ones (Nicholas 1998).

A major dilemma for jobseekers then, is whether to divulge a mental illness to prospective employers. Honest

information may undermine employability, but failure to disclose may result in dismissal or other consequence (such as loss of benefits) when the truth finally comes to light. Mental health consumers often recommend keeping psychiatric treatment a secret, preferring to explain long absences from work with fictional or fake diagnoses, such as "exhaustion" (Schulze and Angermeyer 2003). In a study comparing patients who were hospitalized for medical and psychiatric reasons, over half with a past psychiatric hospitalization would hide this from their workmates, whereas none of those with a medical hospitalization would. The majority of workmates of psychiatric patients (64%) did not know the nature of their colleague's hospitalization, whereas all of the workmates of medical patients did (McCarthy et al. 1995). Although the literature on disclosure is generally sparse, and there are no Canadian studies, there is some evidence from the United States that appropriate job matching may eliminate the need to disclose a psychiatric diagnosis to an employer (Dalgin and Gilbride 2003).

### **Stigma and Underemployment**

Workers are underemployed when their jobs are inferior to their normal occupations or are economically inadequate. Underemployment may also include a psychological dimension if it entails lower job satisfaction with the non-economic aspects of the work, such as poor or disrupted relationships with co-workers or low decision latitude. Although thought to be pervasive among the mentally ill and other disadvantaged groups, underemployment has no official definition or statistics that are routinely collected or reported (Dooley 2003). Thus, the

epidemiology of under-employment among disabled groups is unknown. However, like unemployment, underemployment is thought to result in health and mental health effects (Dooley 2003; Grzywacz and Dooley 2003).

The jobs considered most suitable for people with a mental illness often involve menial labour, do not provide opportunities for skill development, do not promote a sense of mastery, negatively impact self-esteem and are a tangible source of psychological stress (Scheid 1999). In a survey of mental health consumers in the United States, one in three reported being counselled to take jobs below their educational level, intellect or training (Wahl 1999a). Most of those who will work in such jobs will last an average of only six months (Henry and Lucca 2002). Twenty-five percent of those with a psychiatric disability will have a job within 18 months, compared to half of those with a physical disability, but fewer than 15% of those with a previous psychiatric hospitalization will keep a job for five years (Botterbusch and Osgood 1997).

Mental health consumers who return to work often return to positions of reduced responsibility with little or no psychosocial support from former colleagues and workmates (Simmie and Nunes 2001; Nunes and Simmie 2002). As well, they may be the brunt of critical comments, such as "without you things were running more smoothly" (Schulze and Angermeyer 2003: 307). Using anecdotal experiences reported by Canadian mental health consumers, Figure 2 illustrates that it can be as difficult to keep a job as it is to get one once one's mental illness is known. Indeed, as many as half of the competitive jobs acquired by people with a serious mental

illness end unsatisfactorily because of problems that occur once the job is in progress (Becker et al. 1998).

People with mental illnesses may face the highest degree of workplace discrimination of any disabled group. In the United States, mental disorders are the second-most common basis for charges of discrimination and workplace harassment (under the Americans with Disabilities Act), constituting 10% of all discrimination cases and 13% of all cases of workplace harassment (Scheid 1999).

Knowledge about how to make workplace accommodations for people with mental health problems is scant; however, there is growing agreement that organizational cultures must be modified to be more receptive to and tolerant of people with psychiatric disabilities (Scheid 1999). Workplace rehabilitation policies of the 1970s and 1980s inadvertently perpetuated underemployment by segregating those with serious mental illnesses in sheltered or transitional workplaces where wages were substandard and job mobility into the competitive labour market was rare (Drake et al. 1998). Since then, supported employment programs, although not widespread, provide competitive employment opportunities for people with psychiatric disabilities. Evaluations of supported employment and consumer-run businesses demonstrate that people with mental illnesses, even severe and persistent illnesses, can successfully obtain and maintain competitive employment (Latimer 2001; Krupa et al. 2003). At least one study has shown that regional variation in unemployment rates among those with a serious mental disorder can be linked to the availability (or unavailability) of supported employment programs (Drake et al. 1998). Virtually nothing is known about the effectiveness of other

workplace intervention strategies, such as educational programs or employee assistance programs, in diminishing employment inequity.

### **Self-stigma**

Self-stigma occurs when negative social stereotypes are internalized and a mental illness comes to be viewed as a personal failure. Self-stigma results in a loss of self-esteem and self-efficacy and a reluctance to participate in social interactions (Holmes and River 1998). With respect to work, fear of stigma and rejection can undermine confidence with the result that people with a mental illness may make a poorer showing in job interviews. Over time, they will view themselves as ineffective and unemployable and will avoid job interviews altogether (Link 1982; Wahl 1999a). Indeed, 69% of mental health consumers responding to a recent US survey indicated they had not applied for jobs for fear of unfair treatment (Wilson 2004). However, research done in the UK civil service has shown that job performance reviews of people with psychiatric morbidity (presumably morbidity that was unknown to co-workers) were no worse than those of their symptom-free counterparts. Job performance was uncorrelated with symptom level (Nicholas 1998).

The anxiety and fear that workmates will find out may exact a significant psychological toll as well as increase workplace disability and cost. People with mental illnesses will go to great lengths to ensure that others do not find out, including staying in unsatisfactory situations for fear that moving will result in disclosure, avoiding friendships and avoiding treatment. In Ontario, for example, workers with mental health problems are less likely to take time off than are those with

---

**Figure 2: Real People, Real Stories....**

---

*Work places can be like an army that shoots its wounded.*  
*I have known people to "pretend" they have a physical problem and that's why they're away from work.*  
*I have had to lie to get a job rather than admit to having a mental health problem.*  
*They encourage you to use the Employee Assistant Program, but god help you if you actually use it...then you become 'labeled', and they use it against you.*  
*I didn't know what my rights were as an employee, and I didn't have the strength to deal with them. I wanted to believe them when they said they cared.... I was vulnerable.... I was bullied.*  
*I need a job that can help me build up my self-esteem and give me a feeling of being self-sufficient.*  
*When I wasn't well, I didn't have the strength to stand up for myself.*  
*They made it so hard for me at work; I think they were trying to force me to quit.*  
*Mental health issues happen to anyone. It is beneath me to beg for a chance to work.*  
*I was told not to talk to anyone at work about what I was going through....*  
*When I don't feel well, I need to feel secure that I can take the time I need, and not lose my job.*  
*They treated me like a 'broken product' that you just discard if some small part isn't working the same as before.*

Excerpts from *Real People, Real Stories....* (Mental Health Matters 2001)

---

physical conditions and are more likely to struggle through at sub-optimal work levels (Dewa and Lin 2000). In the United States, psychiatric disability has been associated with both work loss and work cutback days. The association of psychiatric disorder with work cutback days was greater for professional workers than for those in other occupations (Kessler and Frank 1997).

Lack of knowledge on the part of managers and supervisors hampers early recognition and speedy resolution of mental health problems in the workplace. "Managers can go a long way in lifting the veil of secrecy and ambivalence, which often surrounds mental health, by creating a climate in which open discussion of such concerns is not only tolerated but encouraged" (Schott 1999: 173). However, even when employee assistance programs are available, they may create and reinforce stigma and discrimination by calling into question the very competence and employment suitability of the individuals receiving services. Among military

personnel returning from Bosnia, for example, 61% agreed that admitting to a psychological problem would harm their careers. By comparison only 43% thought that admitting to a medical problem would be harmful (Britt 2000).

### **Strategic Directions for Future Research**

The twentieth century stands out as a period of great awakening, not only with respect to the recognition of the frequency of mental disorders in populations, but their associated human, social and economic costs. It is now recognized that good mental health is an essential component of both social and economic capital. The influence of work on mental health has been of interest to Canadian researchers for over a decade (Baba et al. 1998) but not yet from the perspective of stigma. In light of the gaps outlined in the previous discussion, three priorities for stigma research are suggested for inclusion in a national research agenda on mental health and work.

**First Priority: Increase Targeted Research to Focus on Mental Health Stigma and Work**

There are many gaps in our current knowledge of stigma and work. Although generally scant, the bulk of existing research comes from the United States or United Kingdom and focuses on stigma as a consequence of serious mental disorders. Virtually nothing is known about the extent and nature of workplace stigma in Canada, particularly as it applies to the full range of mental health problems likely to be found in workplaces. Attempting to understand the attitudes, behaviour and motivations of Canadian employers from data collected in social and economic systems with fundamentally different philosophical positions on work, economics, healthcare, social welfare, workplace disability, mental healthcare and a range of other socio-cultural and economic issues is fraught with difficulty, since all of these things can impact workplace environments. Only through a clear understanding of the nature and extent of workplace stigma in Canada can interventions be designed and appropriately targeted.

Therefore, a **first priority** for a Canadian research agenda must be to gain a better understanding of the extent and nature of mental health related stigma in Canadian workplaces, its determinants and its socio-economic consequences. Studies that should receive highest priority include research on the following:

- Knowledge, attitudes and practices of Canadian employers with respect to the range of mental health problems found in Canadian workplaces
- Employment and workplace experiences of people with mental health problems in order to depict the extent and nature of

stigma and its consequences, including the factors leading to job instability, underemployment and employment

- Social and organizational characteristics (such as policies, procedures, management structures or programs) that promote or impede stigma in the workplace
- How socio-demographic factors such as age, gender, ethnicity or socio-economic status may interact with mental health stigma to compound workplace disadvantage
- Analyses of legal and policy frameworks that reduce workplace stigma

**Second Priority: Population Data on Stigma and Work**

Despite the heavy burden of mental disorders, Canada does not have a mental health surveillance plan, although one has been under discussion for some time (Beauséjour 2001). Statistics Canada does collect selected mental health information through the Community Health Survey, but the schedule for future collection of mental health data have not yet been defined, and there is no current plan to include items that would broaden our understanding of stigma and work. For example, only two items on the current release of the Community Health Survey address stigma and neither bears any relevance to stigma experienced in the workplace. The creation of population-based data that can be used by researchers to better understand workplace stigma is, therefore, a **second priority** for a national research agenda. To this end, consideration should be given to including a workplace mental health module in an upcoming cycle of the Community Health Survey. Strategic funding initiatives developed through theme-based institutes could then be used to support secondary analyses of these data.



### Third Priority: Creating Business-Research Alliances

In recognition of the economic implications of workplace mental health, the business community has now come together in several Canadian cities to examine ways of addressing this problem (Beauséjour 2001). The first Canadian business roundtable on mental health was held in 1998 in Ontario. The group recognized that Canadians have entered an economy of "mental performance" where the mental health of working populations and their families will be increasingly central to the successful workings of the twenty-first century economy. In recognition of the role played by stigma in relation to work, one of the goals identified in their Charter is to "defeat" the stigma attached to mental illness through workplace education (Global Business and Economic Roundtable of Addiction and Mental Health 2003).

Workplace anti-stigma programs and other such interventions require rigorous evaluation. Although increasing numbers of researchers are comfortable in conducting program evaluations, and Canada's capacity for conducting mental health services research is growing, formal alliances between researchers and the business community in this area are noticeably absent. The Canadian Institutes of Health Research, through partnerships between theme-based Institutes, has an opportunity to take a more active role in creating the business-research alliances necessary to foster applied research and evaluation in workplace mental health. Not only would such collaborations give researchers opportunities to strengthen their knowledge of the mechanisms underlying workplace stigma, but they would also assist business leaders in their

pursuit of cost-effective best practices in stigma reduction. Therefore, creating research opportunities that partner applied researchers with business leaders, particularly employers who wish to undertake and evaluate workplace anti-stigma programs, is the **third priority** in support of a comprehensive national research agenda on mental health and work.

### References

- Baba, V., J. Muhammad and L. Tourigny. 1998. "Work and Mental Health: A Decade in Canadian Research." *Canadian Psychology* 39: 94-107.
- Beauséjour, P. 2001. "Advocacy and Misadventures in Canadian Psychiatry." In Q. Rae-Grant, ed., *Psychiatry in Canada: 50 Years* (pp. 137-48). Ottawa: *Canadian Psychiatric Association*.
- Becker, D.R., R.E. Drake, G.R. Bond, H. Xie, B.J. Dain, and K. Harrison. 1998. "Job Terminations among Persons with Severe Mental Illness Participating in Supported Employment." *Community Mental Health Journal* 34(1): 71-82.
- Bland, R.C., G. Stebelsky, H. Orn and S.C. Newman. 1988. "Psychiatric Disorders and Unemployment in Edmonton." *Acta Psychiatrica Scandinavica* 77: 72-80.
- Botterbusch, K.F. and K. Osgood. 1997. "Community-based Assessment of Persons with Psychiatric Disabilities." *Vocational Evaluations and Work Adjustment Bulletin* 30: 36-43.
- Britt, T.W. 2000. "The Stigma of Psychological Problems in a Work Environment: Evidence from Screening of Services Members Returning from Bosnia." *Journal of Applied Social Psychology* 30: 1599-1618.
- Canadian Human Rights Commission. 2003. *Barrier-Free Employers: Practical Guide for Employment Accommodation for People with Disabilities*. Retrieved August 8, 2003. <<http://www.chrc-ccdp.ca/ee/bfe/eso.asp>>.
- Canadian Mental Health Association, Ontario Division. 1994. *Final Report: Mental Health Anti-Stigma Campaign Public Education Strategy*.
- Crowther, R.E., M. Marshall, G.R. Bond and P. Huxley. 2001. "Helping People with Severe Mental Illness to Obtain Work: Systematic Review." *British Medical Journal* 322: 204-8.
- Dalgin, R.S. and D. Gilbride. 2003. "Perspectives

- of People with Psychiatric Disabilities on Employment Disclosure." *Psychiatric Rehabilitation Journal* 26(3): 306-10.
- Dewa, C.S. and E. Lin. 2000. "Chronic Physical Illness, Psychiatric Disorder and Disability in the Workplace." *Social Science and Medicine* 51(1): 41-50.
- Dickerson, F.B., J. Sommerville, A.E. Origoni, N.B. Ringel and F. Parente. 2002. "Experiences of Stigma Among Outpatients with Schizophrenia." *Schizophrenia Bulletin* 28(1): 143-52.
- Dooley D. 2003. "Unemployment, Underemployment, and Mental Health: Conceptualizing Employment Status as a Continuum." *American Journal of Community Psychology* 32: 9-20.
- Dovidio, J.F., B. Major and J. Crocker. 2000. "Stigma: Introduction and Overview." In *The Social Psychology of Stigma* (pp. 1-28). New York: Guilford Press.
- Drake, R.E., T.S. Fox, P.K. Leather, D.R. Becker, J.S. Musumeci, W.F. Ingram and G.J. McHugo. 1998. "Regional Variation in Competitive Employment for Persons with Severe Mental Illness." *Administration and Policy in Mental Health* 25(5): 493-504.
- Falk, G. 2001. *Stigma: How We Treat Outsiders*. New York: Prometheus Books.
- Global Business and Economic Roundtable on Addiction and Mental Health. 2003. *The Charter on Addiction and Mental Health in the Global Economy*. Retrieved October 20, 2003. <<http://www.mentalhealthroundtable.ca>>.
- Goffman, E. 1963. *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice-Hall.
- Grzywacz, J.G. and D. Dooley. 2003. "'Good Jobs' to 'Bad Jobs': Replicated Evidence of an Employment Continuum from Two Large Surveys." *Social Science and Medicine* 56: 1749-60.
- Gullekson, M. 1992. "Stigma: Families Suffer Too." In *Stigma and Mental Illness*, 11-12. Washington: American Psychiatric Press.
- Henry, A.D. and A.M. Lucca. 2002. "Contextual Factors and Participation in Employment for People with Serious Mental Illness." *The Occupational Therapy Journal of Research* 22 (Supp.): 835-36.
- Holmes, E.P. and L.P. River. 1998. "Individual Strategies for Coping with the Stigma of Severe Mental Illness." *Cognitive and Behavioral Practice* 5: 231-39.
- Jones, J. 2001. "Roots of Stigma?" *Mental Health Matters*. Waterloo, ON: Canadian Mental Health Association, Waterloo Regional Branch and the Wellington-Dufferin Branch.
- Kates, N., B.S. Greiff and D.Q. Hagen. 1990. *The Psychosocial Impact of Job Loss*. Washington, DC: American Psychiatric Press.
- Kendell, R.E. 2004. "Foreword: Why Stigma Matters." In A.H. Crisp, ed., *Every Family in the Land: Understanding Prejudice and Discrimination Against People with Mental Illness* (pp. xxi-xxiii). London: Royal Society of Medicine Press.
- Kessler, R. and R. Frank. 1997. "The Impact of Psychiatric Disorders on Work Loss Days." *Psychological Medicine* 27: 861-73.
- Krupa, T., M. Lagarde and K. Carmichael. 2003. "Transforming Sheltered Workshops into Affirmative Businesses: An Outcome Evaluation." *Psychiatric Rehabilitation Journal* 26(4): 359-67.
- Latimer, E.A. 2001. "Economic Impacts of Supported Employment for Persons with Severe Mental Illness." *Canadian Journal of Psychiatry* 46(6): 496-505.
- Leete, E. 1992. "The Stigmatized Patient." In Fink, P.J. and A. Tasman, eds., *Stigma and Mental Illness* (pp. 17-25). Washington, DC: American Psychiatric Press.
- Lefley, H.P. 1992. "The Stigmatized Family." In Fink, P.J. and A. Tasman, eds., *Stigma and Mental Illness* (pp. 127-38). Washington, DC: American Psychiatric Press.
- Link, B. 1982. "Mental Patient Status, Work, and Income: An Examination of the Effects of a Psychiatric Label." *American Sociological Review* 47: 202-15.
- Link, B.G., J. Mirotznik and F.T. Cullen. 1991. "The Effectiveness of Stigma Coping Orientations: Can Negative Consequences of Mental Illness Labelling Be Avoided?" *Journal of Health and Social Behavior* 32: 302-20.
- Long, E. and B. Runch. 1983. "Combating Stigma through Work for the Mentally Restored." *Hospital and Community Psychiatry* 34(1): 19-20.
- Macias, C., L.T. DeCario, Q. Wang, J. Frey and P. Barreira. 2001. "Work Interest as a Predictor of Competitive Employment: Policy Implications for Psychiatric Rehabilitation." *Administration and Policy in Mental Health* 28(4): 279-97.
- Manning, C., and P.D. White. 1995. "Attitudes of Employers to the Mentally Ill." *Psychiatric Bulletin* 19: 541-43.

- Markowitz, F.E. 1998. "The Effects of Stigma on the Psychological Well-being and Life Satisfaction of Persons with Mental Illness." *Journal of Health and Social Behaviour* 39: 335-47.
- McCarthy, J., R. Prettyman and T. Friedman. 1995. "The Stigma of Psychiatric Inpatient Care." *Psychiatric Bulletin* 19: 349-51.
- McQuilken, M., J.H. Zahniser, J. Novak, R.D. Starks, A. Oimos and G.R. Bond. 2003. "The Work Project Survey: Consumer Perspectives on Work." *Journal of Vocational Rehabilitation* 18: 59-68.
- Mental Health Matters. 2001. Published jointly by the Canadian Mental Health Association, Waterloo Regional Branch and the Wellington-Dufferin Branch 14(1): 6-7.
- Nicholas, G. 1998. "Workplace Effects on the Stigmatization of Depression." *The Journal of Occupational and Environmental Medicine* 40(9): 793-800.
- Nunes, J. and S. Simmie. 2002. *Beyond Crazy*. Toronto: McClelland & Stewart.
- Prince, P.N. and C.R. Prince. 2002. "Perceived Stigma and Community Integration among Clients of Assertive Community Treatment." *Psychiatric Rehabilitation Journal* 25(4): 323-31.
- Roeloffs, C., C. Sherbourne, J. Unützer, A. Fink, J. Tang and K.B. Wells. 2003. "Stigma and Depression among Primary Care Patients." *General Hospital Psychiatry* 25: 311-15.
- Sartorius, N. 2004. "The World Psychiatric Association Global Programme against Stigma and Discrimination because of Stigma." In A.H. Crisp, ed., *Every Family in the Land* (pp. 373-75). (Revised edition) London: Royal Society of Medicine Press.
- Scheid, T.L. 1999. "Employment of Individuals with Mental Disabilities: Business Response to the ADA's Challenge." *Behavioral Sciences and the Law* 17: 73-91.
- Schott, R.L. 1999. "Managers and Mental Health: Mental Illness and the Workplace." *Public Personnel Management* 28(2): 161-83.
- Schulze, B. and M.C. Angermeyer. 2003. "Subjective Experiences of Stigma. A Focus Group Study of Schizophrenic Patients, Their Relatives and Mental Health Professionals." *Social Sciences and Medicine* 56: 299-312.
- Simmie, S. and J. Nunes. 2001. *The Last Taboo: A Survival Guide to Mental Health Care in Canada*. McClelland & Stewart.
- Smith, M. 2002. "Stigma." *Advances in Psychiatric Treatment* 8: 317-25.
- Stip, E., J. Caron and C.J. Lane. 2001. "Schizophrenia: People's Perceptions in Quebec." *Canadian Medical Association Journal* 164(9): 1299-1300.
- Stuart, H. 2003a. "Violence and Mental Illness: An Overview." *World Psychiatry* 2(2): 121-24.
- Stuart, H. 2003b. "Stigma and the Daily News: Evaluation of a Newspaper Intervention." *Canadian Journal of Psychiatry* 48(10): 301-6.
- Stuart, H. and J. Arboleda-Flórez. 2001. "Community Attitudes toward People with Schizophrenia." *Canadian Journal of Psychiatry* 46: 245-52.
- Thompson, A.H. and R.C. Bland. 1995. Social Dysfunction and Mental Illness in a Community Sample. *Canadian Journal of Psychiatry* 40: 15-20.
- Thompson, A.H., H. Stuart, R.C. Bland, J. Arboleda-Flórez, R. Warner and R. Dickson. 2002. "Attitudes about Schizophrenia from the Pilot Site of the WPA Worldwide Campaign against the Stigma of Schizophrenia." *Social Psychiatry and Psychiatric Epidemiology* 37: 475-82.
- Wahl, O.F. 1999a. "Mental Health Consumers' Experiences of Stigma." *Schizophrenia Bulletin* 25(3): 467-78.
- Wahl, O.F. 1999b. *Telling is Risky Business*. Piscataway, New Jersey: Rutgers University Press.
- Wahl, O.F. and F.R. Harman. 1989. "Family Views of Stigma." *Schizophrenia Bulletin* 5(1): 131-39.
- Wilson, M. 2004. "The Social Impact of Stigmatization on Users and Carers." In *Every Family in the Land: Understanding Prejudice and Discrimination Again People with Mental Illness* (pp. 72-77). London: Royal Society of Medicine Press.
- Wolff, G. 1997. "Attitudes of the Media and the Public." *Care in the Community: Illusion or Reality?* London: John Wiley and Sons.
- WHO. 2001. *The World Health Report 2001 – Mental Health: New Understanding and Hope*. Geneva: World Health Organization.

**Practices in Peer Specialist Supervision and  
Employment- New Jersey Psychiatric Rehabilitation  
Association (NJPRA) November 17-18, 2010  
Conference (A4)**

**NJPRA November 17-18, 2010**

*Conference title: Living the values of recovery in policies, programs, and practice*

## **Practices in Peer Specialist Supervision and Employment**

Peer specialists play an increasingly important role in a recovery-oriented service system, yet there are no accepted national standards for defining this role or the essential competencies on which to base training and certification programs. This presentation will provide an up-to-date summary of best practices for peer specialist supervision and employment based on foundation principles, research, and practical experience.

### *Objectives*

At the end of the workshop, participants will be able to:

1. Identify the key competencies of the peer specialist role
2. Explain the concept of “universal design” as applies to employment policies
3. Suggest personnel policies that would effectively support peer staff

In a recent study, “written peer job descriptions ... showed that the expectations of peers were often unreasonable and greatly exceeded the formal specified job responsibilities.”\* (p. 298).

The study authors recommend:

- 1) **Hiring policies** that are responsive to the unique qualifications of peers such as accepting experience in lieu of formal credentials;
- 2) A **job structure** that conveys the importance of peers to the agency, including positions that are permanent and independent of changing levels of funding, compensated and evaluated on the same performance standards as non-peer staff, and provide opportunities for advancement;
- 3) **HR practices** that help peers participate in the workplace to the fullest extent possible;
- 4) **Orientation and training** to all constituencies about the peer role; and
- 5) **Clear communication of the value of peers** in a mission statement that supports recovery, a strong leadership role in supporting the mission, and formalized opportunities to learn about policies and practices such as a mandatory new employee orientation.

\*Gates, L. B., & Akabas, S. H. (2007). *Developing strategies to integrate peer providers into the staff of mental health agencies. Admin Policy in MH and MH Services Research, 34, 293-306. Quote is from p. 298)*

### **Universal Design**

The design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

*The Center for Universal Design NC State University*  
[http://www.design.ncsu.edu/cud/about\\_ud/udprinciplestext.htm](http://www.design.ncsu.edu/cud/about_ud/udprinciplestext.htm)

Human resources policies based on universal design are:

- Simple, intuitive, easy to understand
- Affordable and included in the budget
- Flexible enough to accommodate a wide range of needs
- Developed by involving stakeholders in design and evaluation
- Equitable and relevant to all employees
- Designed to minimize misuse / abuse

## **The Job Description**

A job description provides a summary of the primary duties, responsibilities, and qualifications of a position. It is important to reflect priorities and current expectations.

### **Components of the job description:**

#### *Function:*

Summarize the main purpose of the position within the department/organization in one sentence.

#### *Reporting Relationships*

Describe the “chain of command” and the types of supervision the employee will get and will give, indicating the specific job titles of the supervisors and the positions supervised.

#### *Responsibilities*

List 4 to 6 core responsibilities of the position and identify several specific duties within each of the core responsibility areas.

#### *Qualifications/Competencies*

List required and preferred qualifications, credentials, and competencies in order of importance. These might include educational requirements (e.g., a high school diploma or equivalency), training or certification as a peer specialist, or specify that the employee must be a person in recovery (e.g. “Be a self-identified current or former user of mental health or co-occurring services who can relate to others who are now using those services” or “Must be a self-disclosed individual with a mental illness)

#### *Employment Conditions*

Describe any relevant circumstances, such as any physical requirements (e.g., standing, lifting), environmental conditions, unusual work schedule (e.g., rotating shift, on-call hours), and any other requirements (e.g., driver’s license, background check, random drug screen).

#### *Tips from the Small Business Association (<http://www.sba.gov>):*

- A good job description begins with a careful analysis of the important facts about a job, such as tasks involved, methods used to complete the tasks, and the relationship of the job to other jobs.
- It’s important to make a job description practical by keeping it dynamic, functional, and current.
- Don’t get stuck with an inflexible job description! A poor job description will keep you and your employees from trying anything new and learning how to perform their job more productively. A well-written, practical job description will help you avoid hearing a refusal to carry out a relevant assignment because “it isn’t in my job description.”

[http://www.sba.gov/smallbusinessplanner/manage/manageemployees/SERV\\_JOBDESC.html](http://www.sba.gov/smallbusinessplanner/manage/manageemployees/SERV_JOBDESC.html)

**NJPRA November 17-18, 2010**

*Conference title: Living the values of recovery in policies, programs, and practice*

## **Sample Peer Specialist Job Description Components\***

### Sample function statements

- Provide vision driven hope and encouragement to support people in their recovery and assist them in connecting to the community
- Provides opportunities for individuals receiving services to direct their own recovery process (self-determination) and acts as an advocate for the needs and rights of persons served
- Works with individuals in groups and on a one-to-one basis to provide recovery training and outreach to individuals who use mental health services in the community
- Shares personal recovery experiences and develops authentic peer-to-peer relationships
- Offers instruction and support to help people develop the skills they need to facilitate their recovery
- Informs people served of available service options and choices while promoting the use of natural supports and resources within the community
- Supports people to articulate and describe their needs, wants and desires to providers and family members (self-advocacy)
- Provides peer mentoring and support for individuals with psychiatric disabilities receiving mental health services
- Assists individuals in navigating the mental health services system and in achieving resiliency and recovery as defined by the person

### Sample responsibility statements

- Assist in the orientation process for persons who are new to receiving mental health and/or co-occurring disorders services
- Educate and support people in the use of Wellness Plans, including Wellness Recovery Action Plan, as a means to recognize early triggers and signs of relapse, and use of individual coping strategies as an alternative to more restrictive services
- Outreach/accompany to ensure the individual is making a successful transition to community integration and is continuing their progress toward recovery goals
- Support the individual in seeking to connect/reconnect with family, friends, significant others and in learning how to improve or eliminate unhealthy relationships
- Provide education and advocacy within the community that promotes awareness of psychiatric disorders while reducing misconceptions, prejudice, and discrimination
- Keep treatment team informed about individual's strengths, accomplishments and obstacles in relation to their recovery goals
- Complete all required documentation in a timely, legible manner
- Educate professional staff about the recovery process and the damaging role that stigma can play in undermining recovery
- Visit community resources with people using services to assist them in becoming familiar with potential opportunities
- Facilitate (via personal coaching and WRAP groups) the transition from a professionally directed service plan to a self-directed Recovery Plan
- Model personal responsibility, self-advocacy, and hopefulness through telling one's personal recovery story, how needs are respectfully met, and how a belief in oneself is maintained
- Ensures confidentiality of individual information
- Assess emergency situations, notifies supervisor and/or appropriate clinical and administrative personnel of actual or potential problems
- Exhibits a nonjudgmental approach, effective listening, good eye contact, and positive interactions

\*adapted from job descriptions and materials from Pennsylvania, North Carolina, Recovery Innovations of Arizona, Florida Peer Network Inc., the Transformation Center (Boston, MA), and Collaborative Support Programs of NJ

**NJPRA November 17-18, 2010**

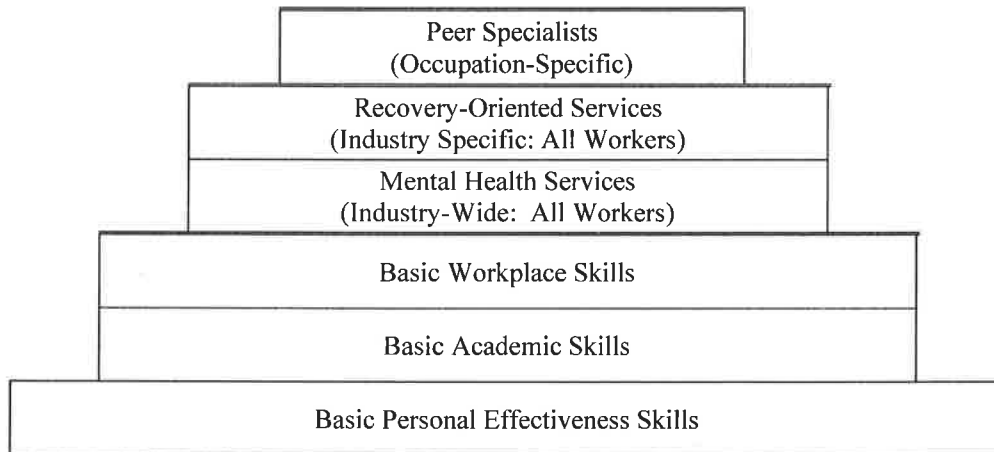
*Conference title: Living the values of recovery in policies, programs, and practice*

## **Training**

Pre-Service ⇒ New Employee Orientation ⇒ On-the-job Training ⇒ Continuing Ed

Our most common approaches to instruction, involving top-down teaching through a lecture format, “have little impact on a clinician’s behavior and essentially no effect on healthcare outcomes.”\*

A competency is the ability to apply or using knowledge, skills, attitudes, and personal characteristics to successfully perform critical work tasks, specific functions, or operate in a given role or position (Ennis, 2008). The *Competency Model Clearinghouse* identifies “tiers” of competencies that can be applied to understanding the job requirements for peer specialists:



*Adapted from the interactive graphic: <http://www.careeronestop.org/competencymodel/pyramid.aspx>*

Most employees need – and get – some level of mentoring when starting a job.

- Some of this is provided by the supervisor, some by line colleagues, and some by non-direct colleagues with whom the employee finds an allegiance.
- In some settings, a staff member may be assigned to focus on training new personnel.
- Even when an employee with a disability gets outside job coaching, the job coach works to taper his/her involvement quickly, in favor of the natural supports in the workplace.

A peer provider in his/her first position may well want to develop a relationship with a more experienced peer provider in that workplace or another one.

- MHANJ offers “Work and Wellness Forums,” which are a kind of support group for peer providers. See: <http://www.mhanj.org/pdf/wellness1.pdf>
- The Consumer Provider Association in NJ ([www.cpanj.org](http://www.cpanj.org)) should also be able to offer this.

\*Stuart, G.W., Hoge, M.A., & Tondora, J. (2004). *Theory and evidence-based teaching strategies: Implications for behavioral health*. Retrieved Jan 25, 2006, from <http://www.annapoliscoalition.org> (quote is from p. 18)



**NJPRA November 17-18, 2010**

*Conference title: Living the values of recovery in policies, programs, and practice*

## **Effective Supervision**

Ultimately, the supervisor represents the service agency or institution in a quality control and quality improvement capacity, but the supervisor also has other responsibilities. At times, these responsibilities may conflict with one another, which can create ethical dilemmas and stress.

- The responsibility to the service agency is to achieve the goal of delivering the highest possible care at the lowest possible cost in the shortest possible time.
- The responsibility to people who use the agency's services is to help them achieve their own goals in the most efficient and supportive way.
- The responsibility to the trainee is to allow ample opportunity to practice and improve.

In human services, supervisors provide both administrative task-oriented supervision and reflective/consultative supervision. These two roles are both complementary and contradictory.

- Administrative supervision focuses on organizational efficiency, with all of the necessary attention on performance measures, required tasks, and urgent deadlines.
- Consultative supervision focuses on the professional development of the supervisee, along with his/her relationships with service users.
- Supervisees often benefit from having separate supervisors for these roles.

Supervisors of peer specialists must be thoroughly familiar with the job role requirements.

- Ideally, each peer specialist will have a reflective/consultative supervisor with experience working as a peer specialist. Someone learning a professional discipline or role benefits from mentorship from someone trained and experienced in that role.
- Peer specialists are often described as "in but not of the system." This position can create job strain, and is an important area to explore routinely in supervision.

Supervisors need to know their limits (boundaries), when to refer to personnel to the EAP.

It's natural for a mental health worker who is a supervisor to try to help a colleague or a direct report using mental health techniques. This does the supervisee, whether a peer or non-peer, a disservice because:

- It blurs or distorts the normal work relationships.
- It may reduce the person's self-efficacy.
- It has the potential to result in either inappropriate disclosure or clumsy "talking around" personal issues.

Supervisory methods and content need to be individualized, and may require negotiation.

- Negotiating a contract for the supervision (timing, content, and process) is helpful.
- The supervisee's cognitive style, conceptual ability, personal approach to problems, and style of interaction are relevant to the supervision process, and need to be valued.

When supervisors share their experiences, especially their mistakes and anxieties, supervisees learn important lessons. Such disclosures create an atmosphere of trust and openness.

*Some content adapted from Bernard & Goodyear. (1998). Fundamentals of clinical supervision (2<sup>nd</sup> ed.) and Bradley & Ladany. (2001). Counselor supervision: Principles, process, and practice. Phila: Brunner-Routledge.*

**NJPRA November 17-18, 2010**

*Conference title: Living the values of recovery in policies, programs, and practice*

### **Summary: Best Practices in Employment of Peer Specialists**

1. Hire people who are qualified to do the job—no tokenism; lived experience by itself is not enough. Peer specialists need relevant work experience and/or training.
2. Clarify the essential functions of the job.
3. Develop a clear job description and provide detailed information about job expectations and requirements. Revisit the job description from time to time to ensure that it is up to date.
4. Apply the principles of universal design when you develop human resources policies that are flexible enough to create an accepting, adaptable program culture that works for everyone.
5. Provide accommodations through a standardized disability policy that applies to everyone. Inform all of your staff about the process for requesting accommodations.
6. Provide competency-based training and supervision, and remember that changing practice (or any habitual behavior pattern) is much more difficult than teaching an inexperienced person the right way from the beginning
7. Separate administrative task-oriented supervision from reflective/consultative supervision.\*
8. Use a qualified and knowledgeable supervisor. If at all possible, use an experienced peer specialist to provide the best supervision for a peer specialist.
9. Enforce requirements through existing and standardized feedback, supervision, and performance evaluation mechanisms.
10. If all else fails, and you are sure that you have provided full support through orientation, training, supervision, performance evaluation, and any needed accommodations, then you need to fire the person who can't do the job.

#### **For more information, most of the following resources are available on-line:**

- California Community College Economic and Workforce Development Program Health Initiative. (2007). DACUM competency profile for behavioral health peer specialist.
- Campbell, J., & Leaver, J. (2003). Emerging new practices in organized peer support. Washington, DC: National Technical Assistance Center for State Mental Health Planning, NASMHPD.
- CASTLE Worldwide. (2007). Role delineation study for the North Carolina Department of Health and Human Services Division of Mental Health, Development Disabilities and Substance Abuse Services: Peer Support Specialist (Executive Summary).
- Chinman, M., Young, A.S., Hassell, J., Davidson, L. (2006). Toward the implementation of mental health consumer provider services. Journal of Behavioral Health Services and Research, 33(2), 176-195.
- Johnson, E. (2008). Minnesota Peer Support Implementation Consultant's Report. Downloaded April 23, 2009, from <http://www.californiaclients.org/pdf/Sue%20Watson%20Presentation%20Attachment.pdf>
- Katz, J., & Salzer, M. (November, 2006). Certified Peer Specialist program descriptions. Philadelphia: University of Pennsylvania Collaborative on Community Integration.
- Mead, S., & MacNeil, C. (December, 2004). Peer support: What makes it unique? (Unpublished).
- RAND (Chinman, M., Hamilton, A., Butler, B., Knight, E., Murray, S., & Young, A.; 2008). Mental health consumer providers: A guide for clinical staff. Arlington, VA: RAND Corporation.
- SAMHSA. (2005). Building a Foundation for Recovery: A Community Education Guide on Establishing Medicaid-Funded Peer Support Services and a Trained Peer Workforce. DHHS Pub. No. (SMA) 05-8089. Rockville, MD: Center for Mental Health Services, Substance Abuse and M H Services Admin.
- Stoneking, B.C., & McGuffin, B.A. (2007). A review of the constructs, curriculum, and training data from a workforce development program for recovery support specialists. Psychiatric Rehabilitation Journal, 31(2), 97-106.

**Reciprocal Supervision: How Peer Specialists and  
Their Supervisors Can Work Together for Lasting  
Recovery Best Practices in Employment of Peer  
Specialist (A5)**

## **Reciprocal Supervision: How Peer Specialists and Their Supervisors Can Work Together for Lasting Recovery**

By M. C. Violet Taylor

*This article was originally published on the SAMHSA Recovery to Practice Website April 2012.*

Reciprocal Supervision is a term I coined to describe the egalitarian relationship I have with my supervisor. She is the Assistant Chief Nursing Executive in a locked mental health institute and I am a Regional Peer Bridger—the consumer on staff. We work in an acute care setting, where the spectrum of mental health issues, cultures, languages, abilities, and lifestyles is as varied among consumers as it is among coworkers. Our State has not been as progressive as it has been diverse. Peer Support Specialists are still a rarity, and we are the signal of changes to come.

There is a true understanding of the concept "unconditional high regard" in the working relationships I've developed with my supervisors at the hospital. We have incorporated key elements of the Wellness Recovery Action Plan (WRAP) in our relationships, emphasizing Hope, Personal Responsibility, Education, Self-Advocacy, and Support to benefit everyone—especially the consumers we serve.

Peer Support Specialists take a different approach to mental health and recovery. Relationships are based on trust, and we emphasize the strengths a consumer has already developed or has the capacity to develop. Among peers, reciprocity and discretion are implicit. You might say we work "from the heart out," with an appreciation for the preciousness of each other's humanity. It goes without saying that we all strive to support and understand one another.

My focus is to help people return to work and their communities and, most importantly, begin the recovery process. Cleaning a consumer's home to ease his return from the hospital, waiting in the car during a peer's job interview, shopping with someone for work clothes and supplies ... these are just a few of the tasks we perform, all the while gently encouraging peers to determine what assistance is needed for their recovery. Recovery is always a work in progress. We're constantly changing together.

Each of my four supervisors has been a Recovery Champion. Along with peer leader Lisa Goodwin, the clinical staff have guided me with creativity and patience. Change has taken place at our organization and I believe healthy, strong relationships are part of the reason our consumers are so successful.

My first supervisor was Chief Nursing Executive Amy Rushton, RN. Looking back, I realize she was the driving force behind my work and recovery-oriented care at the hospital. Melissa Preston, Director of Social Work, was my supervisor the following year. She emphasized efficiency and customer service skills. Today I am supervised by Lauren Davis, ACNE, who has allowed me to write about and promote our success. These are women of vision, creativity, and strength.

Over the years, I have learned lessons from my supervisors that I still use today:

### **Ask the Consumer**

When you're not sure about what a person has in mind, ask. Start a dialogue—it will show consumers you support their health, life, and dreams. If they don't know where to begin, help them create a list of viable options.

### **Give Your Supervisors What They Need to Help You!**

At times, staff will question your work. My supervisor attends meetings where she's grilled about my decisions. Because we keep the lines of communication open, she can help me handle difficult staff and administrative hurdles. When my decisions are based on health, safety, and common sense, they can be easily explained to anyone.

### **Make Opportunities for People to Shine**

As a one-peer department, I needed help facilitating groups. When consumers at the hospital heard about peer-led groups, they were anxious. "They can't be in a room alone together!" was the assumption. I responded that people need to be part of a support group where they can speak honestly, without fear of documentation or another diagnosis. My supervisor suggested each peer group leader work with an assistant, so someone would always remain in the room. We started with five peer-led groups and when consumers requested more, we obliged. I now co-lead about 14 groups each week, with help from consumers. Our groups are so effective, we host two at local drop-in centers.

### **Take Time to Speak Out**

Consumers and I are usually responsible for presenting at local conferences. It was difficult to speak publicly at first, but my peers and supervisors brought me along. Allow your Peer Support Specialists to attend local and national conferences. If possible, let them bring consumers.

### **Guidelines I Use to "Manage My Supervisor"**

- Honesty. If I have a problem, I go straight to my supervisor. She has worked in hospitals for a long time and helps me resolve issues quickly.
- Maintain role model transparency with supervisors, consumers, and staff—say what you do and do what you say.
- Respect your supervisor's time. (Have you ever seen a mental health services provider who actually had enough staff?)
- Take time off if you're not feeling well. Use your WRAP to catch early signs of illness.
- Clinicians sometimes teeter on the edge of burnout. Handle as much as you comfortably can on your own and always be kind to consumers. Remember: we are not here to "do" for our peers, only to provide support.
- Tell supervisors about new resources in the community (events, classes, etc.). Bring them information on trends and changes in technology, scholarship offerings, and conferences.
- Let your supervisor know when she's doing well, and how her work has helped people. Note the changes you've made together.

- When you're stuck, ask for help! Some clinicians, especially Recovery Champions, have been waiting for the chance to try something new.

- Peer Support Specialists have two jobs: to serve consumers in ways that promote recovery, and inform their supervisors about what does and doesn't work inside the system. Don't expect solutions to magically appear. It takes time before great changes can be made.

**As Peer Support Specialists working in an organization, we cannot create an atmosphere of "us" and "them."** A string pulled in two directions is destined to break. Instead, show your organization you are all bound together by the sturdy, mutual, and heartfelt desire to help others overcome mental illness. There is no greater goal.

*Violet Taylor is a Regional Peer Bridger in Falls Church, Virginia.*

**Employers' Practical Guide to Reasonable  
Accommodation under the Americans with  
Disabilities Act-Job Accommodation Network (JAN)  
(A6)**

# JAN

**Job Accommodation Network**

Practical Solutions • Workplace Success

## Accommodation and Compliance Series

### Employers' Practical Guide to Reasonable Accommodation Under the Americans with Disabilities Act

Job Accommodation Network  
PO Box 6080  
Morgantown, WV 26506-6080  
(800)526-7234 (V)  
(877)781-9403 (TTY)  
jan@askjan.org  
askjan.org



Office of Disability  
Employment Policy

A service of the U.S. Department of Labor's Office of Disability Employment Policy



## Preface

The Job Accommodation Network (JAN) is a service of the Office of Disability Employment Policy of the U.S. Department of Labor. JAN makes documents available with the understanding that the information be used solely for educational purposes. The information is not intended to be legal or medical advice. If legal or medical advice is needed, appropriate legal or medical services should be contacted.

JAN does not endorse or recommend any products or services mentioned in this publication. Although every effort is made to update resources, JAN encourages contacting product manufacturers/vendors and service providers directly to ensure that they meet the intended purposes. This guarantees that the most up-to-date information is obtained.

The following document is not copyrighted and reproduction is encouraged. Section 105 of the Copyright Law provides that no copyright protection is available for works created by the U.S. Government. Therefore, all works created by JAN fall under this provision. While individuals may use such work with impunity, individuals may not claim copyright in the original government work, only in the original material added. Individuals may access the full text of the law from the U.S. Copyright Office <http://www.loc.gov/copyright>. Please note that specific information cited by JAN may be copyrighted from other sources. Citing secondary sources from a JAN publication may violate another organization's or individual's copyright. Permission must be obtained from these sources on a case-by-case basis. When using JAN materials, JAN asks that the materials not be reproduced for profit, that the tone and substance of the information are not altered, and that proper credit is given to JAN as the source of the information. For further information regarding this or any other document provided by JAN, please contact JAN.

# **EMPLOYERS' PRACTICAL GUIDE TO REASONABLE ACCOMMODATION UNDER THE AMERICANS WITH DISABILITIES ACT**

## **Introduction**

The Job Accommodation Network (JAN) is a free service of the U.S. Department of Labor's Office of Disability Employment Policy. JAN consultants have been providing job accommodation information to employers since 1983 when JAN was founded. In addition, JAN consultants have been providing information to employers about the Americans with Disabilities Act (ADA) since 1992 when the ADA went into effect. Over the years, JAN consultants have developed practical ideas to help employers provide job accommodations and comply with the ADA. The *Employers' Practical Guide to Reasonable Accommodation under the Americans with Disabilities Act* is a summary of some of the most frequent issues that employers have regarding accommodations and ADA compliance and JAN's practical ideas for resolving them. As new information is available or new issues develop, the *Guide* will be updated to reflect the changes. If you have an issue that is not addressed in the *Guide* or if you want to discuss an issue in more detail, please call JAN.

## **TABLE OF CONTENTS**

### **I. ADA BASICS**

**What is the ADA?**

**Who must comply with Title I of the ADA?**

**Who is protected by Title I of the ADA?**

**What is a reasonable accommodation?**

### **II. REASONABLE ACCOMMODATIONS FOR APPLICATIONS AND JOB INTERVIEWS**

**A. Job Advertisements and Applications**

**B. Job Interviews**

**C. Post Job Offer**

### **III. REASONABLE ACCOMMODATION FOR EMPLOYEES**

**A. Policies and Procedures**

**B. Accommodation Requests**

**C. Determining Effective Accommodations**

**D. Accommodation Issues**

**1. Work-site Accessibility**

**2. Job Restructuring**

**3. Modified Work Schedules and Leave**

**4. Modified Policies**

**5. Equipment and Services**

### **IV. REASONABLE ACCOMMODATION FOR EMPLOYEES ON LEAVE AND FORMER EMPLOYEES**

**A. Health and Disability Insurance**

**B. Bonuses and Promotions**

**C. Reductions in Force and Layoffs**

## **I. ADA BASICS**

This section provides answers to basic questions about the ADA. Most of the answers come from formal and informal guidance from the Equal Employment Opportunity Commission (EEOC), the federal agency that enforces the ADA. When available, links to the EEOC guidance are provided.

### **What is the ADA?**

The ADA is a federal civil rights law that was passed in 1990 and went into effect beginning in 1992. Its purpose is to protect people with disabilities from discrimination in employment, in the programs and activities offered by state and local governments, and in accessing the goods and services offered in places like stores, hotels, restaurants, football stadiums, doctors' offices, beauty parlors, and so on. The focus of this guide is Title I of the ADA, which prohibits discrimination in employment and requires employers to provide reasonable accommodations for employees with disabilities.

For more information about the ADA, see the *ADA Handbook* at <http://askjan.org/media/adahandbook/handbook.html>.

For a copy of Title I of the ADA, see <http://www.eeoc.gov/policy/ada.html>.

### **Who must comply with Title I of the ADA?**

Only "covered entities" must comply with Title I of the ADA. The term covered entities includes employers with 15 or more employees, employment agencies, labor organizations, and joint labor-management committees. For simplicity, this guide will refer to covered entities as "employers."

For more information about covered entities, see <http://www.eeoc.gov/policy/docs/threshold.html#2-III-B>.

### **Who is protected by Title I of the ADA?**

Title I protects "qualified employees with disabilities." The term qualified means that the individual satisfies the skill, experience, education, and other job-related requirements of the position sought or held, and can perform the essential job functions of the position, with or without reasonable accommodation.

For additional information about the definition of qualified, see <http://askjan.org/links/ADAtam1.html#II>.

The term employee means, "an individual employed by an employer." The question of whether an employer-employee relationship exists is fact-specific and depends on whether the employer controls the means and manner of the worker's work performance.

For additional information about the definition of employee, see <http://www.eeoc.gov/policy/docs/threshold.html#2-III-A-1>.

The term disability means: (1) a person who has a physical or mental impairment that substantially limits one or more major life activities, (2) a person with a record of a physical or mental impairment that substantially limits one or more major life activities, and (3) a person who is regarded as having a physical or mental impairment that substantially limits one or more major life activities.

For additional information about the definition of disability, visit *How to Determine Whether a Person has a Disability under the Americans with Disabilities Act (ADA)* at <http://askjan.org/corner/vol02iss04.htm>.

On September 25, 2008, the ADA Amendments Act (ADAAA) was passed. This Act changes the interpretation of the definition of disability. For additional information on the ADAAA, visit *Accommodation and Compliance Series: The ADA Amendments Act of 2008*, at <http://askjan.org/bulletins/adaaa1.htm>.

The term essential job functions means the fundamental job duties of the employment position that the individual with a disability holds or desires. The term essential functions does not include marginal functions of the position.

For additional information about essential functions, visit the EEOC's *Title I Technical Assistance Manual* at <http://askjan.org/links/ADAAtam1.html>, section 2.3(a).

### **What is a reasonable accommodation?**

A reasonable accommodation is a modification or adjustment to a job, the work environment, or the way things usually are done that enables a qualified individual with a disability to enjoy an equal employment opportunity. An equal employment opportunity means an opportunity to attain the same level of performance or to enjoy equal benefits and privileges of employment as are available to an average similarly-situated employee without a disability. The ADA requires reasonable accommodation in three aspects of employment: 1) to ensure equal opportunity in the application process, 2) to enable a qualified individual with a disability to perform the essential functions of a job, and 3) to enable an employee with a disability to enjoy equal benefits and privileges of employment.

Examples of reasonable accommodations include making existing facilities accessible; job restructuring; part-time or modified work schedules; acquiring or modifying equipment; changing tests, training materials, or policies; providing qualified readers or interpreters; and reassignment to a vacant position.

For additional information about reasonable accommodation under the ADA, visit *Reasonable Accommodation and Undue Hardship* (EEOC Guidance) at <http://www.eeoc.gov/policy/docs/accommodation.html>.

## **II. REASONABLE ACCOMMODATIONS FOR APPLICATIONS AND INTERVIEWS**

The ADA applies to all aspects of employment, including job advertisements, job applications, job interviews, and post-offer medical examinations. Although many of the ADA rules that apply to applicants and new-hires are the same as the rules for employees, there are some differences. This section discusses the differences.

### **A. Job Advertisements and Applications**

#### **1. What information do employers have to provide about the ADA on job advertisements and job applications?**

No specific information about the ADA is required on job advertisements or job applications. However, the EEOC advises employers to include information about the essential functions of the job in job announcements, advertisements, and other recruitment notices because specific information about essential functions will attract applicants, including individuals with disabilities, who have appropriate qualifications.

The EEOC also advises employers to consider including a statement in job advertisements and notices that they do not discriminate on the basis of disability or other legally prohibited bases. The EEOC provides the following example: "We are an Equal Opportunity Employer. We do not discriminate on the basis of race, religion, color, sex, age, national origin or disability."

For additional information, see the EEOC's *Title I Technical Assistance Manual* at <http://askjan.org/links/ADAtam1.html>.

#### **2. Does the ADA require affirmative action in the hiring of people with disabilities?**

No. The ADA is a nondiscrimination law. It does not require employers to undertake special activities to recruit people with disabilities. However, it is consistent with the purpose of the ADA for employers to expand their "outreach" to sources of qualified candidates with disabilities. Recruitment activities that have the effect of screening out potential applicants with disabilities may violate the ADA.

For example: If an employer conducts recruitment activity at a college campus, job fair, or other location that is physically inaccessible, or does not make its recruitment activity accessible at such locations to people with visual, hearing or other disabilities, it may be liable if a charge of discrimination is filed.

For more information, see the EEOC's *Title I Technical Assistance Manual* at <http://askjan.org/links/ADAtam1.html>.

### **3. Does the ADA allow affirmative action in the hiring of people with disabilities?**

Employers may invite applicants to voluntarily self-identify for purposes of the employer's affirmative action program if the employer is undertaking affirmative action because of a federal, state, or local law that requires affirmative action for individuals with disabilities, or the employer is voluntarily using the information to benefit individuals with disabilities.

According to the EEOC, if an employer invites applicants to voluntarily self-identify in connection with providing affirmative action, the employer must state clearly that the information requested is used solely for affirmative action purposes, that it is being requested on a voluntary basis, that it will be kept confidential in accordance with the ADA, that refusal to provide it will not subject the applicant to any adverse treatment, and that it will be used only in accordance with the ADA.

For additional information, see *Pre-Employment Disability-Related Inquiries and Medical Exams* at <http://www.eeoc.gov/policy/docs/preemp.html>.

### **4. Where can employers find qualified applicants with disabilities?**

According to the U.S. Department of Labor, Office of Disability Employment Policy (ODEP), qualified applicants with disabilities can be located through various resources, including Vocational Rehabilitation (VR). In addition, ODEP co-sponsors the Workforce Recruitment Program (WRP) to connect public and private sector employers nationwide with postsecondary students and recent graduates with disabilities and many colleges and universities have coordinators of services for students with disabilities who can be helpful in recruitment. Employers may also be able to locate qualified applicants with disabilities by contacting local independent living centers or organizations representing people who have specific disabilities.

For a list of VR offices by state, visit <http://askjan.org/cgi-win/TypeQuery.exe?902>.

For information about WRP, visit <http://www.dol.gov/odep/wrp/>.

For free consulting services and resources to support the recruitment and hiring of people with disabilities, visit the Employer Assistance and Resource Network (EARN) at <http://askearn.org>

### **5. What accommodations do employers have to provide during the application process?**

Employers have an obligation to make reasonable accommodations to enable applicants with disabilities to apply for jobs. For example, information about jobs should be available in a location that is accessible to people with mobility impairments. If a job advertisement provides only a telephone number to call for information, a TDD

(telecommunication device for the deaf) number should be included, unless a telephone relay service has been established. Printed job information in an employment office or on employee bulletin boards should be made available, as needed, to persons with visual or other reading impairments. Preparing information in large print will help make it available to some people with visual impairments. Information can be recorded on a cassette or read to applicants with more severe vision impairments and those who have other disabilities that limit reading ability.

For more information about making the application process accessible, see the EEOC's *Title I Technical Assistance Manual* at <http://askjan.org/links/ADAtam1.html>.

#### **6. Do employers have to make on-line application processes accessible?**

Employers must either make their on-line application processes accessible or provide an alternative means for people with disabilities to apply for jobs, unless they can show that doing so would cause an undue hardship.

For information regarding making on-line applications accessible, visit <http://askjan.org/topics/onlineapps.htm>.

#### **7. What medical questions can employers ask on job applications?**

Employers cannot ask disability-related questions before an offer of employment is made. In general, this means that employers cannot ask questions on job applications that are likely to elicit information about a disability. For example, employers cannot ask whether an applicant has a physical or mental impairment, has received workers compensation, or was ever addicted to illegal drugs. For more examples, visit *Pre-Offer, Disability-Related Questions: Dos and Don'ts* at <http://askjan.org/media/preofferfact.doc>.

For additional information about pre-employment medical questions, see *Pre-Employment Disability-Related Inquiries and Medical Exams* at <http://www.eeoc.gov/policy/docs/preemp.html>.

#### **8. How can employers accommodate applicants with disabilities during pre-employment testing?**

The method of accommodation depends on the individual applicant's limitations and the type of test involved, so each situation must be approached on a case by case basis. As a starting point, JAN put together a publication that provides a broad discussion of potential accommodations for testing. The publication is called *Accommodations for Testing* and can be viewed at <http://askjan.org/media/testingaccomm.html>.



## **9. Do employers have to have job descriptions?**

According to the EEOC, the ADA does not require employers to develop or maintain job descriptions. A written job description that is prepared before advertising or interviewing applicants for a job will be considered as evidence in determining essential functions along with other relevant factors. However, the job description will not be given greater weight than other relevant evidence.

The ADA does not limit an employer's ability to establish or change the content, nature, or functions of a job. It is the employer's province to establish what a job is and what functions are required to perform it. The ADA simply requires that an individual with a disability's qualifications for a job be evaluated in relation to the job's essential functions.

For more information about job descriptions, visit *Job Descriptions* at <http://askjan.org/media/jobdescriptions.html>.

## **B. Job Interviews**

### **1. What medical questions can employers ask during a job interview?**

Under the ADA, employers may not ask disability-related questions or conduct medical examinations until after they make a conditional job offer to an applicant. This helps ensure that an applicant's possible hidden disability (including a prior history of a disability) is not considered before employers evaluate an applicant's non-medical qualifications. Employers may not ask disability-related questions or require a medical examination pre-offer even if they intend to look at the answers or results only at the post-offer stage.

Although employers may not ask disability-related questions or require medical examinations at the pre-offer stage, they may do a wide variety of things to evaluate whether an applicant is qualified for the job, including asking about an applicant's ability to perform specific job functions, asking about an applicant's non-medical qualifications and skills, and asking applicants to describe or demonstrate how they would perform job tasks. For more examples, visit *Pre-Offer, Disability-Related Questions: Dos and Don'ts* at <http://askjan.org/media/preofferfact.doc>.

For additional information, visit EEOC's *Pre-employment Disability-Related Inquiries and Medical Exams* at <http://www.eeoc.gov/policy/docs/preemp.html>.

### **2. Where can employers get information about disability etiquette?**

There are a variety of resources for information about disability etiquette. JAN provides a list of some of the available resources on its Website at <http://askjan.org/topics/disetiq.htm>.

### **3. What accommodations must be provided for job interviews?**

Employers have an obligation to make reasonable accommodations to enable applicants with disabilities to participate in the interview process. Accommodations for interviews may include: an accessible interview location for people with mobility impairments, a sign language interpreter for a person who is deaf, a reader for a person who is blind, and modified testing for a person with a learning disability.

For more information about making the job interviews accessible, see the EEOC's *Title I Technical Assistance Manual* at <http://askjan.org/links/ADAtam1.html>.

## **C. Post Job Offer**

### **1. What constitutes a valid job offer?**

A job offer is valid if the employer has evaluated all relevant non-medical information that it reasonably could have obtained and analyzed prior to giving the offer. There may be times when an employer cannot reasonably obtain and evaluate all non-medical information at the pre-offer stage. If an employer can show that is the case, the offer would still be considered a real offer.

Employers do not have to limit offers to current vacancies; they can give offers to fill current vacancies or reasonably anticipated openings. Employers may also give offers that exceed the number of vacancies or reasonably anticipated openings, but must comply with the ADA when taking people out of the pool to fill actual vacancies. The employer must notify an individual (orally or in writing) if his/her placement into an actual vacancy is in any way adversely affected by the results of a post-offer medical examination or disability-related question.

If an individual alleges that disability has affected his/her placement into an actual vacancy, the EEOC will carefully scrutinize whether disability was a reason for any adverse action. If disability was a reason, the EEOC will determine whether the action was job-related and consistent with business necessity.

For additional information, visit EEOC's *Pre-employment Disability-Related Inquiries and Medical Exams* at <http://www.eeoc.gov/policy/docs/preemp.html>.

### **2. What medical questions can employers ask once a job offer has been made?**

According to the EEOC, once a conditional job offer is made and before an employee starts work, employers may ask any disability-related questions they choose and they may require medical examinations as long as this is done for all entering employees in a particular job category.

For additional information, visit EEOC's *Pre-employment Disability-Related Inquiries and Medical Exams* at <http://www.eeoc.gov/policy/docs/preemp.html>.

### **3. Can employers rescind a job offer without violating the ADA?**

In some cases employers may be able to rescind a job offer without violating the ADA. If an employer rejects an applicant after a post offer disability-related question or medical examination and the applicant files a complaint with the EEOC alleging discrimination, EEOC investigators will closely scrutinize whether the rejection was based on the results of that question or examination. If the question or examination screens out an individual because of a disability, the employer must demonstrate that the reason for the rejection is job-related and consistent with business necessity.

In addition, if the individual is screened out for safety reasons, the employer must demonstrate that the individual poses a "direct threat." This means that the individual poses a significant risk of substantial harm to him/herself or others, and that the risk cannot be reduced below the direct threat level through reasonable accommodation.

## **III. REASONABLE ACCOMMODATION FOR EMPLOYEES**

One of the key non-discrimination requirements of Title I of the ADA is the obligation to provide reasonable accommodation for employees with disabilities. This section provides information about what policies and procedures might be useful, how to recognize and handle accommodation requests, how to determine effective accommodations, and what types of accommodations might be reasonable.

### **A. Policies and Procedures**

#### **1. Are there specific policies and procedures employers must follow when trying to accommodate an employee with a disability?**

There are no specific policies or procedures that employers must follow when trying to accommodate an employee with a disability. However, employers may want to develop formal policies and procedures for several reasons. First, if supervisors, managers, and HR professionals have formal policies and procedures to refer to, they are more likely to handle accommodation requests properly and consistently. Second, a formal policy that is shared with employees helps employees know what to expect if they request an accommodation and also helps them understand that other employees might be requesting and receiving accommodations. Finally, formal procedures help employers document their efforts to comply with the ADA.

#### **2. Where can employers get sample accommodation policies and procedures?**

JAN and the EEOC have sample accommodation policies and procedures on their Web sites at:

Sample policies at <http://askjan.org/links/adapolicies.html>

*Five Practical Tips For Providing And Maintaining Effective Job Accommodations at*  
<http://askjan.org/media/FivePracticalTips.doc>

*Establishing Procedures to Facilitate the Provision of Reasonable Accommodation at*  
[http://www.eeoc.gov/policy/docs/accommodation\\_procedures.html](http://www.eeoc.gov/policy/docs/accommodation_procedures.html)

*EEOC's Internal Accommodation Procedures at*  
[http://www.eeoc.gov/eeoc/internal/reasonable\\_accommodation.cfm](http://www.eeoc.gov/eeoc/internal/reasonable_accommodation.cfm)

*EEOC's Practical Advice for Drafting and Implementing Reasonable Accommodation Procedures under Executive Order 13164 at*  
[http://www.eeoc.gov/policy/docs/implementing\\_accommodation.html](http://www.eeoc.gov/policy/docs/implementing_accommodation.html)

### **3. Do employers have any obligation to provide temporary accommodations while researching an employee's accommodation request?**

According to informal guidance from the EEOC, there is no definite answer to this question; it depends on the situation. In some circumstances, it may be a violation of the ADA for an employer to fail to make temporary arrangements to keep an employee working while the employer researches the employee's accommodation request. From a practical standpoint, employers should try to make temporary accommodations, even beyond the requirements of the ADA, because doing so demonstrates the employer's good faith efforts to accommodate. For example, if an employee cannot perform an essential function of his job and requests an accommodation that requires some research, the employer should consider temporarily removing the essential function until a permanent accommodation can be made. If an employer chooses to do this, the employer should make clear to the employee that the interim accommodation is temporary.

## **B. Accommodation Requests**

### **1. How can employers recognize an accommodation request?**

According to the EEOC, an individual may use "plain English" and need not mention the ADA or use the phrase "reasonable accommodation" when requesting an accommodation. Therefore, any time an employee indicates that he/she is having a problem and the problem is related to a medical condition, the employer should consider whether the employee is making a request for accommodation under the ADA. The EEOC provides the following examples:

Example A: An employee tells her supervisor, "I'm having trouble getting to work at my scheduled starting time because of medical treatments I'm undergoing." This is a request for a reasonable accommodation.

Example B: An employee tells his supervisor, "I need six weeks off to get treatment for a back problem." This is a request for a reasonable accommodation.

Example C: A new employee, who uses a wheelchair, informs the employer that her wheelchair cannot fit under the desk in her office. This is a request for reasonable accommodation.

Example D: An employee tells his supervisor that he would like a new chair because his present one is uncomfortable. Although this is a request for a change at work, his statement is insufficient to put the employer on notice that he is requesting reasonable accommodation. He does not link his need for the new chair with a medical condition.

From *Reasonable Accommodation and Undue Hardship under the ADA* at <http://www.eeoc.gov/policy/docs/accommodation.html>

## **2. Who should handle accommodation requests?**

Initially, the person receiving an accommodation request should respond, even if the response is merely to explain the company's accommodation process and refer the employee on to the appropriate person to handle the request. Employers may want to designate a person to handle accommodation requests and then train all supervisors, managers, foremen, crew leaders, HR representatives, and others in positions that involve supervision of employees to consult with that designated person if they receive an accommodation request.

## **3. Can employers ask an employee whether he/she needs an accommodation?**

According to the EEOC, an employer may ask an employee with a known disability whether he/she needs a reasonable accommodation when it reasonably believes that the employee may need an accommodation. For example, an employer could ask a deaf employee who is being sent on a business trip if he/she needs reasonable accommodation. Or, if an employer is scheduling a luncheon at a restaurant and is uncertain about what questions it should ask to ensure that the restaurant is accessible for an employee who uses a wheelchair, the employer may first ask the employee. An employer also may ask an employee with a disability who is having performance or conduct problems if he needs reasonable accommodation.

## **4. Does the ADA have specific accommodation request forms that employers must use?**

No, there are no official request forms under the ADA. For employers that want to have a written request, JAN developed a sample request form located at <http://askjan.org/media/raemployersform.htm>.

## **5. What should employers do when they receive an accommodation request?**

According to the EEOC, the employer and the individual with a disability should engage in an informal process to clarify what the individual needs and identify the appropriate reasonable accommodation. The employer may ask the individual relevant questions that will enable it to make an informed decision about the request. This includes asking what type of reasonable accommodation is needed.

The exact nature of the dialogue will vary. In many instances, both the disability and the type of accommodation required will be obvious, and thus there may be little or no need to engage in any discussion. In other situations, the employer may need to ask questions concerning the nature of the disability and the individual's functional limitations in order to identify an effective accommodation. While the individual with a disability does not have to be able to specify the precise accommodation, he/she does need to describe the problems posed by the workplace barrier. Additionally, suggestions from the individual with a disability may assist the employer in determining the type of reasonable accommodation to provide. Where the individual or the employer are not familiar with possible accommodations, there are extensive public and private resources to help the employer identify reasonable accommodations once the specific limitations and workplace barriers have been ascertained. Employers can always contact JAN free of charge.

## **6. What medical information can employers ask for when an employee requests accommodation?**

Under the ADA, employers must limit the scope of a medical inquiry in response to an accommodation request. When the disability or need for accommodation is not obvious, an employer may require that the employee provide medical documentation to establish that the employee has an ADA disability, to show that the employee needs the requested accommodation, and to help determine effective accommodation options. Although the ADA limits the scope of medical requests, it does not include specific forms for requesting medical information. For employers who want to develop a form, JAN provides a sample format that employers can use as a guide. The form is located at <http://askjan.org/media/medical.htm>.

### **C. Determining Effective Accommodations**

#### **1. How can employers determine effective accommodations?**

In most situations, employers should first consult with the employee who requested the accommodation to clarify what the individual needs and identify the appropriate reasonable accommodation. Often the employee will be the best resource for information about accommodation needs. When the employee does not have all the necessary information or when an employer wants to explore other options, the next step may be to request medical information from the employee's health care provider.

By talking with the employee who requested the accommodation and obtaining medical information if needed, the employer should be able to identify what the problem is, which is the first step in determining effective accommodation solutions. The employer needs to know what specific symptoms and functional limitations are creating barriers to accessing the workplace, performing job tasks, or benefiting from an equal employment opportunity. It may also be helpful to know if the employee's limitations are predictable, subject to change over time, stable, or progressive. While this information may not always be known, when available the information can be very helpful in selecting a long term, effective accommodation solution.

Once the employee's limitations and abilities are identified, the next step is to determine how they impact the employee's ability to perform the job. To make this determination, the employer needs to consider what specific job tasks, work environments, equipment, or policies are creating barriers to successful job performance. A good job description is a starting point, but does not always provide all the information needed. Sometimes it may be necessary to go beyond the traditional job description and consider other factors, such as what equipment is used to perform a task, where the work is performed, and why certain policies are being followed.

After the employer identifies the employee's limitations and abilities and determines how they impact job performance, the employer is ready to consider accommodation options.

For more information on the accommodation process, see:

JAN's *Five Practical Tips For Providing And Maintaining Effective Job Accommodations* at <http://askjan.org/media/FivePracticalTips.doc> and JAN's *Interactive Process* at <http://askjan.org/media/interactiveprocessfact.doc>

## **2. Where can employers get information about the types of accommodations that might be useful?**

JAN provides free consulting services for employers seeking accommodation ideas. JAN also maintains an extensive Web site with accommodation idea publications and a Searchable Online Accommodation Resource (SOAR), which allows employers to independently search for accommodation solutions. JAN's Web site for SOAR is <http://askjan.org/soar>.

## **3. Who chooses an accommodation?**

According to the EEOC, employers get to choose among effective accommodation options. If more than one accommodation would be effective for the individual with a disability, or if the individual would prefer to provide his or her own accommodation, the individual's preference should be given first consideration.

#### **4. What accommodations are not considered reasonable?**

Reasonable accommodation does not include removing essential job functions, creating new jobs, and providing personal need items such as eye glasses and mobility aids. Nothing in the ADA prohibits employers from providing these types of accommodations; they simply are not required accommodations.

#### **5. If an employer provides an accommodation the ADA does not require, will that set a precedent for the next time an employee needs the same type of accommodation?**

The EEOC encourages employers to go beyond the requirements of the ADA if they choose and will not penalize them for doing so. However, if employers choose to do more than required under the ADA, they should do so in a non-discriminatory manner. For example, employers should not do more only for employees with physical disabilities and not for people with mental disabilities.

### **D. Accommodation Issues**

#### **1. Work-Site Accessibility**

##### **a. Do employers have to modify the work-site if they do not have an employee with a mobility impairment?**

Under Title I, an employer is not required to make its existing facilities accessible until a particular applicant or employee with a particular disability needs an accommodation, and then the modifications should meet that individual's work needs. The employer does not have to make changes to provide access in places or facilities that will not be used by that individual for employment related activities or benefits. However, private employers that occupy commercial facilities or operate places of public accommodation and state and local governments must conform to more extensive accessibility requirements under Title III and Title II when making alterations to existing facilities or undertaking new construction.

When making changes to meet an individual's needs under Title I, an employer will find it helpful to consult the applicable Department of Justice accessibility guidelines as a starting point. It is advisable to make changes that conform to these guidelines, if they meet the individual's needs and do not impose an undue hardship, since such changes will be useful in the future for accommodating others. However, even if a modification meets the standards required under Title II or III, further adaptations may be needed to meet the needs of a particular individual.

For example: A restroom may be modified to meet standard accessibility requirements (including wider door and stalls, and grab bars in specified locations) but it may be necessary to install a lower grab bar for a very short person in a wheelchair so that this person can transfer from the chair to the toilet.



Although the requirement for accessibility in employment is triggered by the needs of a particular individual, employers should consider initiating changes that will provide general accessibility, particularly for job applicants, since it is likely that people with disabilities will apply for jobs in the future.

From the EEOC's *Title I Technical Assistance Manual*, chapter 3, section 3.10 at <http://askjan.org/links/ADAtam1.html#III>.

For a copy of the ADA Accessibility Guidelines, visit <http://www.access-board.gov/adaag/html/adaag.htm>.

**b. Do employers have to provide accommodations for emergency evacuation?**

If an employer has an emergency evacuation plan for employees, the plan should include employees with disabilities. If an employer does not have an evacuation plan for all employees, the employer must consider accommodations on a case by case basis for any employee with a disability who requests accommodations for emergency evacuation.

For information about accommodating employees during emergency evacuation, visit *Emergency Evacuation Procedures for Employees with Disabilities* at <http://askjan.org/media/emergency.html>.

For information about emergency preparedness and people with disabilities, visit <http://www.dol.gov/odep/programs/emergency.htm>.

**c. Do employers have to provide parking as an accommodation?**

Parking is considered a benefit of employment. Under the ADA, employers must make reasonable accommodations that enable employees with disabilities to enjoy equal benefits of employment. Therefore, if an employer provides parking for all employees, then it must provide parking for employees with disabilities, unless it would pose an undue hardship to do so. A tougher question is whether an employer has to provide parking for employees with disabilities when it does not provide parking for other employees.

There are two ways to look at this issue. First, you could argue that an employer is only required to provide reasonable accommodations that eliminate barriers in the work environment and parking is outside the work environment. Therefore, an employer would not have to provide parking as an accommodation, unless parking is provided for other employees. Alternatively, you could argue that an employer is required to provide parking as an accommodation because otherwise some employees with disabilities would not be able to access the work-site, and therefore providing parking is a way to provide equal employment opportunities to employees with disabilities. Unfortunately, we cannot say which argument is right.

For more information, visit *Parking and the ADA, Act I* at <http://askjan.org/corner/vol01iss14.htm>.

**d. Do employers have to provide transportation to and from work as an accommodation?**

As mentioned in the prior section, an employer is required to provide reasonable accommodations that eliminate barriers in the work environment only, not ones that eliminate barriers outside of the work environment. Therefore, an employer would not be required to provide transportation as a reasonable accommodation for a commute to work, unless the employer generally provides transportation for its employees. However, where an employer's policy regarding work schedules creates a barrier for an individual whose disability interferes with his or her ability to commute to work, the employer must modify that policy as a reasonable accommodation unless it would impose an undue hardship. For example, an individual who uses a wheelchair and commutes by public transportation may need a later arrival time in inclement weather.

From an EEOC informal guidance letter dated June 15, 1997.

**2. Job Restructuring**

According to the EEOC, job restructuring includes modifications such as: reallocating or redistributing marginal job functions that an employee is unable to perform because of a disability; and altering when and/or how a function, essential or marginal, is performed. An employer never has to reallocate essential functions as a reasonable accommodation, but can do so if it wishes.

**a. How do employers determine what job duties are essential?**

JAN put together a publication called *Job Descriptions* at <http://askjan.org/media/jobdescriptions.html>, which includes a discussion about how to determine whether a job duty is essential.

The EEOC also provides information about determining essential functions at section 2.3(a) of its *Title I Technical Assistance Manual* at <http://askjan.org/links/ADAtam1.html>.

**b. Do employers have to provide light duty for employees with disabilities?**

The term "light duty" has a number of different meanings in the employment setting. Generally, "light duty" refers to temporary or permanent work that is physically or mentally less demanding than normal job duties. Some employers use the term "light duty" to mean simply excusing an employee from performing those job functions that he/she is unable to perform because of an impairment. "Light duty" also may consist of particular positions with duties that are less physically or mentally demanding created specifically for the purpose of providing alternative work for employees who are unable

to perform some or all of their normal duties. Further, an employer may refer to any position that is sedentary or is less physically or mentally demanding as "light duty."

In the following discussion, the term "light duty" refers only to particular positions created specifically for the purpose of providing work for employees who are unable to perform some or all of their normal duties.

An employer need not create a light duty position for a non-occupationally injured employee with a disability as a reasonable accommodation. The principle that the ADA does not require employers to create positions as a form of reasonable accommodation applies equally to the creation of light duty positions. However, an employer must provide other forms of reasonable accommodation required under the ADA. For example, subject to undue hardship, an employer must: (1) restructure a position by redistributing marginal functions that an individual cannot perform because of a disability, (2) provide modified scheduling (including part time work), or (3) reassign a non-occupationally injured employee with a disability to an equivalent existing vacancy for which he/she is qualified. Accordingly, an employer may not avoid its obligation to accommodate an individual with a disability simply by asserting that the disability did not derive from an occupational injury.

On the other hand, if an employer reserves light duty positions for employees with occupational injuries (does not create new light duty jobs when needed), the ADA requires it to consider reassigning an employee with a disability who is not occupationally injured to such positions as a reasonable accommodation. This is because reassignment to a vacant position and appropriate modification of an employer's policy are forms of reasonable accommodation required by the ADA, absent undue hardship. An employer cannot establish that the reassignment to a vacant reserved light duty position imposes an undue hardship simply by showing that it would have no other vacant light duty positions available if an employee became injured on the job and needed light duty.

Note that an employer is free to determine that a light duty position will be temporary rather than permanent.

For more information, visit *Workers' Compensation and the ADA* (EEOC) at <http://www.eeoc.gov/policy/docs/workcomp.html>.

### **3. Modified Work Schedules and Leave**

In its publication on reasonable accommodation and undue hardship, the EEOC discusses modified work schedules and leave as accommodations. The information is available at <http://www.eeoc.gov/policy/docs/accommodation.html>. However, some issues regarding work schedules and leave are not addressed in the guidance.

#### **a. Do employers have to change full-time jobs to part-time as an accommodation under the ADA?**

Although part-time work is a form of reasonable accommodation, employers probably do not have to change existing full-time jobs to part-time as an accommodation under the ADA. According to informal guidance from the EEOC, when an employee is asking to cut his/her hours in significantly, then, in essence, the employee is asking for a reassignment to an existing part-time job. The precise legal rationale will be debated in courts for awhile, but any way you look at it you fundamentally change a job when you significantly cut the hours (e.g., in half). One argument is that cutting a job in half necessarily entails cutting essential functions if "essential function" embodies the amount of work to be accomplished. You could also say that you would be cutting the production standard, which is not simply an hourly standard, but also a standard that measures how much should be produced in a full-day.

Another legal argument is to say that significantly reducing the hours of a job would be changing a qualification standard of the job; specifically, the ability to work full-time. The employer should always be able to show that it created a full-time position because there is sufficient work that requires working full-time. As such, the qualification to work full-time meets the business necessity standard, and thus it is not a reasonable accommodation to cut the hours in half.

That is why a request for part-time work by an employee often ends up really being a request for a reassignment to an existing part-time job. If there is only a minimal cut in hours, it might be possible to show that the essential functions, the productivity standard, and/or a qualification standard of the position will not be changed, despite the slight decrease in hours. In this case, an employer might need to eliminate marginal functions to permit the employee to complete all the essential functions.

**b. If an employer chooses to change a full-time job to part-time, does the employer have to maintain the employee's full-time pay and benefits?**

No, not under the ADA unless the employer maintains pay and benefits for employees without disabilities whose jobs change from full-time to part-time. Employers should consider whether other laws apply, such as wage and hour laws.

**c. How much leave time must an employer provide as an accommodation under the ADA?**

Unlike the Family and Medical Leave Act (FMLA), which requires covered employers to provide up to 12 weeks of leave, there is no specific amount of leave time required under the ADA. Instead, leave time is approached like any other accommodation request: the employer must provide the amount of leave needed by the employee unless doing so poses an undue hardship.

For additional information regarding the interplay between the ADA and the FMLA, visit *FMLA, ADA, and Title VII* (EEOC Guidance) at <http://www.eeoc.gov/policy/docs/fmlaada.html>.

#### **4. Modified Policies**

##### **a. Can employers apply a no-fault attendance policy?**

No. If an employee with a disability needs additional unpaid leave as a reasonable accommodation, the employer must modify its "no-fault" leave policy to provide the employee with the additional leave, unless it can show that: (1) there is another effective accommodation that would enable the person to perform the essential functions of his/her position, or (2) granting additional leave would cause an undue hardship. Modifying workplace policies, including leave policies, is a form of reasonable accommodation.

From *Reasonable Accommodation and Undue Hardship* (EEOC Guidance) at <http://www.eeoc.gov/policy/docs/accommodation.html>.

##### **b. Can employers have 100% restriction-free policies?**

According to informal guidance from the EEOC, requiring an employee to be 100% restriction-free can violate the ADA when applied to an employee with a disability. Although some courts have characterized such policies as per se violations of the ADA, most courts require that the employee meet the definition of disability before being allowed to challenge the policy under the ADA. If an employee does not meet the first two prongs, he may be able to show that his employer regarded him as having a disability, typically by relying on evidence that the employer would not let him return to his regular job or any other job in a class of jobs or broad range of jobs in various classes.

##### **c. Can employers enforce conduct rules?**

An employer never has to excuse a violation of a uniformly applied conduct rule that is job-related and consistent with business necessity. This means, for example, that an employer never has to tolerate or excuse violence, threats of violence, stealing, or destruction of property. An employer may discipline an employee with a disability for engaging in such misconduct if it would impose the same discipline on an employee without a disability. An employer must make reasonable accommodation to enable an otherwise qualified employee with a disability to meet such a conduct standard in the future, barring undue hardship, except where the punishment for the violation is termination. Since reasonable accommodation is always prospective, an employer is not required to excuse past misconduct even if it is the result of the individual's disability.

From *Reasonable Accommodation and Undue Hardship* (EEOC Guidance) at <http://www.eeoc.gov/policy/docs/accommodation.html>.

For additional information, visit *The ADA: Applying Performance and Conduct Standards to Employees with Disabilities* at <http://www.eeoc.gov/facts/performance-conduct.html>.

**d. Do employers have to modify dress codes or hygiene requirements as an accommodation?**

Most authorities (including EEOC) treat dress codes and hygiene requirements as "conduct rules," but classify them as the type of conduct rule that must be justified as job-related and consistent with business necessity before being enforced. Therefore, if a person with a disability requests modification of a dress code or hygiene requirement as an accommodation, an employer must consider allowing the modification unless the employer can show that the dress code or hygiene requirement is necessary for the job at issue.

For information about handling hygiene issues in the workplace, visit <http://askjan.org/media/employmenthygienefact.doc>.

For additional information, visit *The ADA: Applying Performance and Conduct Standards to Employees with Disabilities* at <http://www.eeoc.gov/facts/performance-conduct.html>.

**e. Do employers have to consider allowing employees to work at home as an accommodation?**

Yes. Changing the location where work is performed may fall under the ADA's reasonable accommodation requirement of modifying workplace policies, even if the employer does not allow other employees to telework. However, an employer is not obligated to adopt an employee's preferred or requested accommodation and may instead offer alternate accommodations as long as they would be effective.

For more information about work at home as an accommodation, visit *Work at Home/Telework as a Reasonable Accommodation* at <http://www.eeoc.gov/facts/telework.html>.

## **5. Equipment and Services**

**a. If an employer requires work equipment, such as steel-toed work boots or stethoscopes, and an employee with a disability needs specialized equipment that costs more than the regular equipment (e.g., customized boots or amplified stethoscopes), does the employer have to pay the extra cost for the specialized equipment?**

If the equipment or device is a personal-use item, then the employer does not have to provide it. For example, if an employee has to wear a special type of boot all the time,

the employer does not have to pay for it. Common items that fall into this category are hearing aids, glasses, and medication.

On the other hand, if the boots are necessary only for work and constitute an accommodation, the employer would have to pay the entire cost of the boot, unless it would be an undue hardship to do so.

There is also a tool of the trade issue here. If the boots constitute a tool of the trade, that is the boots are necessary to get the job done, then the employer must pay for the specialized boot as a form of equal treatment if the employer provides the boots for other employees. However, if other employees buy their own boots and they own them, then an employee with a disability can be required to buy his own boots even if they cost more.

**b. If an employee has a limitation such as a hearing impairment, but chooses not to purchase a hearing aid, does the employer then have an obligation to provide a hearing aid at work?**

The fact that an individual chooses to forego personal use items at home (a wheelchair, hearing aids, protective clothing) does not mean that such items become work-related because they are needed on the job. The limitations prompting the need for the hearing aids exist on and off the job and thus they remain personal use items.

However, employers may still have to provide a reasonable accommodation even though they are not obligated to provide personal use items. For example, an employer might have to provide an amplified telephone or alternative means of communication for an employee with a hearing impairment who does not choose to use hearing aids.

**c. Do employers have to allow employees with disabilities to use personal need items (canes, walkers, wheelchairs, hearing aids) or services (personal attendant care, service animals) in the workplace?**

Allowing an employee with a disability to use a personal need item or service in the workplace is a form of reasonable accommodation. For example, it would be a reasonable accommodation for an employer to permit an individual who is blind to use a guide dog at work, even though the employer would not be required to provide a guide dog for the employee.

From EEOC regulations for Title I at: <http://frwebgate.access.gpo.gov/cgi-bin/get-cfr.cgi?TITLE=29&PART=1630&SECTION=16&YEAR=2000&TYPE=TEXT>.

**d. Do employers have to provide personal assistance services (PAS) under the ADA?**

The term PAS can include a wide variety of services. The Ticket-to-Work and Work Incentives Improvement Act defines PAS as "a range of services provided by 1 or more persons designed to assist an individual with a disability to perform daily living activities on or off the job that the individual would typically perform without assistance if the individual did not have a disability." Under the ADA, reasonable accommodation can include PAS in the form of work-related assistance, but generally does not include PAS in the form of personal attendant care at the work-site. Work-related PAS can include task-related assistance at work, such as readers, interpreters, help with lifting or reaching, page turners, a travel attendant to act as a sighted guide to assist a blind employee on occasional business trips, and re-assignment of non-essential duties to co-workers.

For additional information, visit *Personal Assistance Services (PAS) in the Workplace* at <http://askjan.org/media/PAS.html>.

**e. Do employers have to provide personal attendant care for work-related travel?**

According to informal guidance from the EEOC, the ADA does not require employers to provide personal attendant care on the job because reasonable accommodation does not require employers to provide personal need items or services. However, when an employee travels for work and incurs personal attendant care expenses beyond his/her usual expenses when not traveling for work, there is a good argument that the employer must pay the added costs.

**f. What if coworkers voluntarily assist employees with disabilities with personal needs? For example, coworkers assist an employee who uses a wheelchair to transfer from her car into her wheelchair when she arrives at work. Do employers have to allow coworkers to assist or can they prohibit them from doing so?**

According to informal guidance from the EEOC, in general employers can decide how employees use their time at work. Therefore, employers can probably prohibit coworkers from providing personal assistance to employees with disabilities without violating the ADA outright. However, from a practical standpoint, the EEOC recommends that employers take a case by case approach and consider allowing coworkers to voluntarily assist employees with disabilities when the employer does not have any liability for resulting injuries and the assistance does not substantially disrupt the workplace.



The EEOC suggests the following approach:

When deciding whether to allow coworkers to provide personal assistance, employers may first want to determine whether they have any liability for resulting injuries. To make that determination, employers should check with appropriate legal advisors - the EEOC does not advise employers about the extent of their liability for on the job injuries. If an employer determines that it is liable for injuries, it can prohibit coworkers from providing the personal assistance. If, on the other hand, the employer determines it is not liable, then the employer should look at other factors such as how much disruption there will be to the workplace if coworkers are allowed to provide personal assistance. If not liable and little if any disruption would result, then the employer should consider allowing coworkers to assist an employee with a disability, at least with minor activities such as taking off and putting on a coat and eating. When more difficult assistance is needed, such as toileting transfers or administering medications, the employer may want to make sure that coworkers are properly trained before allowing them to provide this type of assistance.

In contrast, under the ADA's reasonable accommodation obligation employers must consider allowing employees with disabilities to have their own personal attendant in the workplace, absent undue hardship.

**g. Is it a reasonable accommodation to provide a job coach?**

Yes. An employer may be required to provide a temporary job coach to assist in the training of a qualified individual with a disability as a reasonable accommodation, barring undue hardship. An employer also may be required to allow a job coach paid by a public or private social service agency to accompany the employee at the job site as a reasonable accommodation.

From *Psychiatric Disabilities and the ADA* (EEOC Guidance) at <http://www.eeoc.gov/policy/docs/psych.html>.

**h. Do employers have to provide accommodations for on-the-job travel such as driving to home visits?**

According to the EEOC, employers must consider accommodations such as alternative methods of transportation for work-related travel when driving is not an essential function of the job. For example, an employer must consider alternative transportation for a social worker who cannot drive due to vertigo; the essential function is completing the home visits, not driving.

**IV. REASONABLE ACCOMMODATION FOR EMPLOYEES ON LEAVE AND FORMER EMPLOYEES**

The ADA requires employers to provide accommodations to ensure that employees with disabilities receive equal benefits of employment. For employees on leave and former

employees, benefits of employment may include health and disability insurance, job protection, and bonuses and promotions.

## **A. Health and Disability Insurance**

### **1. Does the ADA apply to employer-sponsored benefits such as health insurance and short and long term disability?**

According to the EEOC, the interplay between the nondiscrimination principles of the ADA and employer-sponsored benefits such as health insurance and short and long term disability can be very complex. The EEOC has two publications that may help employers understand how the ADA applies to employer-sponsored benefits:

*Interim Enforcement Guidance On the Application of the Americans With Disabilities Act of 1990 to Disability-Based Distinctions In Employer Provided Health Insurance* at <http://www.eeoc.gov/policy/docs/health.html>.

*Employee Benefits* at <http://www.eeoc.gov/policy/docs/benefits.html>.

### **2. When employers offer long term disability insurance, can they condition the receipt of payments on termination of employment? Does this potentially violate the ADA's requirement that employers consider holding jobs for people who take leave as an accommodation (assuming the employee has a disability and plans to return to work at some point)?**

Generally this practice does not violate the ADA. Long term disability is a benefit of employment that employers are free to offer or not. As such, employers set the parameters of the benefit. An employer might violate the ADA if the employer's purpose was to evade its obligations under the ADA, but that would be difficult to prove since the employer did not have to offer the benefit in the first place.

### **3. Can an employer terminate or reduce an individual's health insurance benefits because he or she is working fewer hours due to a disability?**

Yes, according to the EEOC. The ADA does not prohibit the adoption of health insurance eligibility requirements that do not discriminate on the basis of disability, as long as such requirements are applied in the same manner to all employees. A requirement that employees work a certain number of hours to remain eligible for health insurance benefits does not discriminate on the basis of disability. It limits both individuals with and without disabilities. Thus, for example, an employee who works reduces hours for some other reason, such as attending school, would also be subject to a reduction or loss of health insurance benefits.

From an EEOC informal guidance letter dated January 4, 1995.

## **B. Bonuses and Promotions**

**If an employer bases bonuses or promotions on employee performance records and attendance, can the employer penalize an employee for work missed during leave taken as a reasonable accommodation?**

No, according to the EEOC, to do so would be retaliation for the employee's use of a reasonable accommodation to which he/she is entitled under the law. Moreover, such punishment would make the leave an ineffective accommodation, thus making an employer liable for failing to provide a reasonable accommodation.

From *Reasonable Accommodation and Undue Hardship under the ADA*, question 19, at <http://www.eeoc.gov/policy/docs/accommodation.html>.

**C. Reductions in Force and Layoffs**

**1. Does the ADA protect employees with disabilities from termination during a reduction in force or from being laid off when business is slow?**

Although the ADA protects individuals with disabilities against discrimination on the basis of disability, employees with disabilities are not protected against non-discriminatory layoffs. When deciding to terminate or layoff employees, employers need to make sure that their decisions are based on business needs, rather than on a desire to get rid of employees with disabilities. For example, employers can base their layoff decisions on such non-discriminatory criteria as productivity, seniority, or job category. However, if an employer bases its layoff decisions on productivity of employees, it cannot penalize employees for accommodations that were provided under the ADA. The EEOC gives the following example:

Company X is having a reduction-in-force. The company decides that any employee who has missed more than four weeks in the past year will be terminated. An employee took five weeks of leave for treatment of his disability. The company cannot count those five weeks in determining whether to terminate this employee.

From *Reasonable Accommodation and Undue Hardship under the ADA*, question 19, at <http://www.eeoc.gov/policy/docs/accommodation.html>.

**2. Are former employees covered by the ADA?**

Former employees are protected by the ADA when they are subjected to discrimination arising from the former employment relationship. For example, an employer cannot release confidential medical information about a former employee.

From *Threshold Issues (EEOC Guidance)* at <http://www.eeoc.gov/policy/docs/threshold.html>.

Updated 05/15/09.

This document was developed by the Job Accommodation Network, funded by a contract agreement from the U.S. Department of Labor, Office of Disability Employment Policy (DOL079RP20426). The opinions expressed herein do not necessarily reflect the position or policy of the U.S. Department of Labor. Nor does mention of trade names, commercial products, or organizations imply endorsement by the U.S. Department of Labor.

## Forward Health Wisconsin Update 2012 (A7)

**Affected Programs:** BadgerCare Plus, Medicaid

**To:** Advanced Practice Nurse Prescribers with Psychiatric Specialty, Community Recovery Services Providers, Community Support Programs, Comprehensive Community Service Providers, Crisis Intervention Providers, Master's-Level Psychotherapists, Outpatient Mental Health Clinics, Outpatient Substance Abuse Clinics, Physician Clinics, Physicians, Psychologists, Psychiatrists, HMOs and Other Managed Care Programs

## 2012 Rate Changes for Services Receiving Only Federal Funds

This *ForwardHealth Update* describes changes to the federal share reimbursement rates for the following services:

- Community Support Programs.
- Comprehensive Community Services.
- Crisis Intervention.
- Outpatient Mental Health and Substance Abuse in the Home or Community for Adults.
- Community Recovery Services.

### Changes to the Federal Share and Reimbursement Amounts

Effective for claims processed and paid on and after October 1, 2012, the federal share will decrease from 60.53 percent to 59.74 percent for the following services:

- Community Support Program (CSP) services.
- Comprehensive Community Services.
- Crisis Intervention Services.
- Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults.
- Community Recovery Services (CRS).

Wisconsin Medicaid will pay up to the federal share of the contracted rates for these services. If the provider's usual and customary charge for the service is less than the contracted rate, Wisconsin Medicaid will pay the federal share of the usual and customary charge. The usual and customary charge is defined as the provider's charge for providing the same

services to persons not entitled to Medicaid or BadgerCare Plus benefits.

To ensure that claims are paid at the appropriate level, providers are reminded to bill using their usual and customary charge.

Providers are responsible for the state share. The state share must be paid from nonfederal public funds.

### Contracted Rates Remain Unchanged

The contracted rates for CSP services, Crisis Intervention Services, Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults, and CRS remain unchanged.

The contracted rate is the uniform rate determined by the Department of Health Services and required by the Medicaid state plan.

### Updated Maximum Allowable Fees

Refer to Attachments 1-5 of this *Update* for the updated maximum allowable fees for services provided to Wisconsin Medicaid and BadgerCare Plus Standard Plan members.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).

P-1250

# ATTACHMENT 1

## Maximum Allowable Fees for Community Support Program Services

Wisconsin Medicaid-enrolled providers will be reimbursed up to the rates listed on this attachment for covered services provided to members enrolled in Wisconsin Medicaid and BadgerCare Plus.

This Attachment contains the following information:

<b>Procedure Code</b>	The procedure code recognized by Wisconsin Medicaid and BadgerCare Plus to identify the service provided.
<b>Description</b>	An abbreviated description of the procedure code.
<b>Contracted Rate</b>	The uniform rate determined by the Division of Health Care Access and Accountability (DHCAA).
<b>Maximum Allowable Fee</b>	The federal share of the contracted rate. Wisconsin Medicaid will pay up to the maximum allowable fee for covered services.

This attachment does not address the various coverage limitations routinely applied before final payment is determined (e.g., member enrollment, provider certification, billing instructions, frequency of services, third-party liability, copayment, age restrictions, and prior authorization).

For questions about the fees, providers should contact Provider Services at (800) 947-9627. For questions about rates, providers should contact the DHCAA by writing to the following address:

Policy Analyst  
Division of Health Care Access and Accountability  
Community Support Program Services  
PO Box 309  
Madison WI 53701-0309



**Maximum Allowable Fees for Community Support Program Services**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Modifier Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
H0039	Assertive community treatment, face-to-face, per 15 minutes	UA — Psychiatrist	\$37.51	\$22.70	\$22.41
		UB — Advanced Practice Nurse Prescriber with psychiatric specialty	\$37.51	\$22.70	\$22.41
		HP — Doctoral level	\$28.14	\$17.03	\$16.81
		HO — Masters degree level	\$22.51	\$13.63	\$13.45
		HN — Bachelors degree level	\$15.00	\$9.08	\$8.96
		HM — Less than Bachelor degree level	\$5.63	\$3.41	\$3.36
		U4 — Group, MD/Advanced Practice Nurse Prescriber with psychiatric specialty	\$9.38	\$5.68	\$5.60
		U3 — Group, Ph.D.	\$7.03	\$4.26	\$4.20
		U2 — Group, Masters	\$5.63	\$3.41	\$3.36
		U1 — Group, Bachelors	\$3.75	\$2.27	\$2.24

# **ATTACHMENT 2**

## **Maximum Allowable Fees for Comprehensive Community Services**

Wisconsin Medicaid-enrolled providers will be reimbursed up to the rates listed on this attachment for covered services provided to members enrolled in Wisconsin Medicaid and BadgerCare Plus.

This Attachment contains the following information:

<b>Procedure Code</b>	The procedure code recognized by Wisconsin Medicaid and BadgerCare Plus to identify the service provided.
<b>Description</b>	An abbreviated description of the procedure code.
<b>Maximum Daily Rate</b>	The maximum daily reimbursement rate determined by the Division of Health Care Access and Accountability (DHCAA).
<b>Maximum Allowable Fee</b>	The federal share of the maximum daily rate. Wisconsin Medicaid will pay up to the maximum allowable fee for covered services.

This attachment does not address the various coverage limitations routinely applied before final payment is determined (e.g., member enrollment, provider certification, billing instructions, frequency of services, third-party liability, copayment, age restrictions, and prior authorization).

For questions about the fees, providers should contact Provider Services at (800) 947-9627. For questions about rates, providers should contact the DHCAA by writing to the following address:

Policy Analyst  
Division of Health Care Access and Accountability  
Comprehensive Community Services  
PO Box 309  
Madison WI 53701-0309

<b>Maximum Allowable Fees for Comprehensive Community Services</b>				
<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Maximum Daily Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
H2018	Psychosocial rehabilitation services, per diem	\$2,000.00	\$1,210.60	\$1,194.80

*Note:* Claims for Comprehensive Community Services are reconciled at the end of the fiscal year.

# ATTACHMENT 3

## Maximum Allowable Fees for Crisis Intervention Services

Wisconsin Medicaid-enrolled providers will be reimbursed up to the rates listed on this attachment for covered services provided to members enrolled in Wisconsin Medicaid and BadgerCare Plus.

This maximum allowable fee schedule contains the following information:

<b>Procedure Code</b>	The procedure code recognized by Wisconsin Medicaid and BadgerCare Plus to identify the service provided.
<b>Description</b>	An abbreviated description of the procedure code.
<b>Contracted Rate</b>	The uniform rate determined by the Division of Health Care Access and Accountability (DHCAA).
<b>Maximum Allowable Fee</b>	The federal share of the contracted rate. Wisconsin Medicaid will pay up to the maximum allowable fee for covered services.

This attachment does not address the various coverage limitations routinely applied before final payment is determined (e.g., member enrollment, provider certification, billing instructions, frequency of services, third-party liability, copayment, age restrictions, and prior authorization).

For questions about the fees, providers should contact Provider Services at (800) 947-9627. For questions about rates, providers should contact the DHCAA by writing to the following address:

Policy Analyst  
Division of Health Care Access and Accountability  
Crisis Intervention Services  
PO Box 309  
Madison WI 53701-0309

<b>Maximum Allowable Fees for Crisis Intervention Services</b>					
<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Modifier Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
S9484	Crisis intervention mental health services, per hour	UA — Psychiatrist	\$148.16	\$89.68	\$88.51
		UB — Advanced Practice Nurse Prescriber with psychiatric specialty	\$148.16	\$89.68	\$88.51
		HP — Doctoral level	\$110.23	\$66.72	\$65.85
		HO — Masters degree level	\$88.90	\$53.81	\$53.11
		HN — Bachelors degree level	\$88.90	\$53.81	\$53.11
		U7 — Paraprofessional	\$47.42	\$28.70	\$28.33
S9485	Crisis intervention mental health services, per diem	None	\$139.54	\$84.46	\$83.36

# **ATTACHMENT 4**

## **Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults**

Wisconsin Medicaid-enrolled providers will be reimbursed up to the rates listed on this attachment for covered services provided to members enrolled in Wisconsin Medicaid and BadgerCare Plus.

This maximum allowable fee schedule contains the following information:

<b>Procedure Code</b>	The procedure code recognized by Wisconsin Medicaid and BadgerCare Plus to identify the service provided.
<b>Description</b>	An abbreviated description of the procedure code.
<b>Contracted Rate</b>	The uniform rate determined by the Division of Health Care Access and Accountability (DHCAA). For medication management (90862), this is the rate for 15 minutes.
<b>Maximum Allowable Fee</b>	The federal share of the contracted rate. Wisconsin Medicaid will pay up to the maximum allowable fee for covered services.

This attachment does not address the various coverage limitations routinely applied before final payment is determined (e.g., member enrollment, provider certification, billing instructions, frequency of services, third-party liability, copayment, age restrictions, and prior authorization).

For questions about the fees, providers should contact Provider Services at (800) 947-9627. For questions about rates, providers should contact the DHCAA by writing to the following address:

Policy Analyst  
Division of Health Care Access and Accountability  
Mental Health and Substance Abuse Services  
PO Box 309  
Madison WI 53701-0309

**Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
90801	Psychiatric diagnostic interview examination (quantity of 1 = 1 hour)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$150.04	\$90.82	\$89.63
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication (quantity of 1 = 1 hour)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$150.04	\$90.82	\$89.63
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	UA — MD, Psychiatrist	\$75.02	\$45.41	\$44.82
		UB — APNP with Psychiatric Specialty	\$45.02	\$27.25	\$26.89
		HP — Doctoral level	\$56.27	\$34.06	\$33.62
		HO — Masters degree level	\$45.02	\$27.25	\$26.89
90805	with medical evaluation and management services	UA — MD, Psychiatrist	\$75.02	\$45.41	\$44.82
		UB — APNP with Psychiatric Specialty	\$75.02	\$45.41	\$44.82

**Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults (Continued)**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90807	with medical evaluation and management services	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$150.04	\$90.82	\$89.63
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	UA — MD, Psychiatrist	\$225.06	\$136.23	\$134.45
		UB — APNP with Psychiatric Specialty	\$135.06	\$81.75	\$80.68
		HP — Doctoral level	\$168.80	\$102.17	\$100.84
		HO — Masters degree level	\$135.06	\$81.75	\$80.68
90809	with medical evaluation and management services	UA — MD, Psychiatrist	\$225.06	\$136.23	\$134.45
		UB — APNP with Psychiatric Specialty	\$225.06	\$136.23	\$134.45



**Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults (Continued)**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient;	UA — MD, Psychiatrist	\$75.02	\$45.41	\$44.82
		UB — APNP with Psychiatric Specialty	\$45.02	\$27.25	\$26.89
		HP — Doctoral level	\$56.27	\$34.06	\$33.62
		HO — Masters degree level	\$45.02	\$27.25	\$26.89
90811	with medical evaluation and management services	UA — MD, Psychiatrist	\$75.02	\$45.41	\$44.82
		UB — APNP with Psychiatric Specialty	\$75.02	\$45.41	\$44.82
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90813	with medical evaluation and management services	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$150.04	\$90.82	\$89.63

**Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults (Continued)**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;	UA — MD, Psychiatrist	\$225.06	\$136.23	\$134.45
		UB — APNP with Psychiatric Specialty	\$135.06	\$81.75	\$80.68
		HP — Doctoral level	\$168.80	\$102.17	\$100.84
		HO — Masters degree level	\$135.06	\$81.75	\$80.68
90815	with medical evaluation and management services	UA — MD, Psychiatrist	\$225.06	\$136.23	\$134.45
		UB — APNP with Psychiatric Specialty	\$225.06	\$136.23	\$134.45
90845	Psychoanalysis (quantity of 1 = 60 minutes)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90846	Family psychotherapy (without the patient present) (quantity of 1 = 60 minutes)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79

**Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults (Continued)**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
90847	Family psychotherapy (conjoint psychotherapy) (with patient present) (quantity of 1 = 60 minutes)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90849	Multiple-family group psychotherapy (quantity of 1 = 60 minutes)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90853	Group psychotherapy (other than of a multiple-family group) (quantity of 1 = 60 minutes)	UA — MD, Psychiatrist	\$37.51	\$22.70	\$22.41
		UB — APNP with Psychiatric Specialty	\$22.51	\$13.63	\$13.45
		HP — Doctoral level	\$28.11	\$17.01	\$16.79
		HO — Masters degree level	\$22.51	\$13.63	\$13.45
90857	Interactive group psychotherapy (quantity of 1.0 = 60 minutes)	UA — MD, Psychiatrist	\$37.51	\$22.70	\$22.41
		UB — APNP with Psychiatric Specialty	\$22.51	\$13.63	\$13.45
		HP — Doctoral level	\$28.11	\$17.01	\$16.79
		HO — Masters degree level	\$22.51	\$13.63	\$13.45

**Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults (Continued)**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
90862	Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (quantity of 1.0 = 15 minutes)	UA — MD, Psychiatrist	\$37.51	\$22.70	\$22.41
		UB — APNP with Psychiatric Specialty	\$37.51	\$22.70	\$22.41
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes	UA — MD, Psychiatrist	\$75.02	\$45.41	\$44.82
		UB — APNP with Psychiatric Specialty	\$45.02	\$27.25	\$26.89
		HP — Doctoral level	\$56.27	\$34.06	\$33.62
		HO — Masters degree level	\$45.02	\$27.25	\$26.89
90876	approximately 45-50 minutes	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79

**Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults (Continued)**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
90880	Hypnotherapy (quantity of 1 = 60 minutes)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient (quantity of 1.0 = 60 minutes)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$150.04	\$90.82	\$89.63
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
90899	Unlisted psychiatric service or procedure (quantity of 1.0 = 60 minutes)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		UB — APNP with Psychiatric Specialty	\$90.04	\$54.50	\$53.79
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79

**Maximum Allowable Fees for Outpatient Mental Health and Substance Abuse Services in the Home or Community for Adults (Continued)**

<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Modifier and Description</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid Through 9/30/12</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12</b>
H0005	Alcohol and/or drug services; group counseling by a clinician [quantity of 1.0 = 60 minutes]	UA — MD, Psychiatrist	\$37.51	\$22.70	\$22.41
		HP — Doctoral level	\$28.11	\$17.01	\$16.79
		HO — Masters degree level	\$22.51	\$13.63	\$13.45
		HN — Bachelors degree level	\$15.01	\$9.09	\$8.97
H0022	Alcohol and/or drug intervention service (planned facilitation) [quantity of 1.0 = per person in group per 60 minutes]	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
		HN — Bachelors degree level	\$60.00	\$36.32	\$35.84
T1006	Alcohol and/or substance abuse services, family/couple counseling (quantity of 1.0 = 60 minutes)	UA — MD, Psychiatrist	\$150.04	\$90.82	\$89.63
		HP — Doctoral level	\$112.53	\$68.11	\$67.23
		HO — Masters degree level	\$90.04	\$54.50	\$53.79
		HN — Bachelors degree level	\$60.00	\$36.32	\$35.84

# ATTACHMENT 5

## Maximum Allowable Fees for Community Recovery Services

Wisconsin Medicaid-enrolled providers will be reimbursed up to the rates listed on this attachment for covered services provided to members enrolled in Wisconsin Medicaid and BadgerCare Plus.

This maximum allowable fee schedule contains the following information:

<b>Procedure Code</b>	The procedure code recognized by Wisconsin Medicaid and BadgerCare Plus to identify the service provided.
<b>Description</b>	An abbreviated description of the procedure code.
<b>Contracted Rate</b>	The uniform rate determined by the Division of Health Care Access and Accountability (DHCAA).
<b>Maximum Allowable Fee</b>	The federal share of the contracted rate. Wisconsin Medicaid will pay up to the maximum allowable fee for covered services.

This attachment does not address the various coverage limitations routinely applied before final payment is determined (e.g., member enrollment, provider certification, billing instructions, frequency of services, third-party liability, copayment, age restrictions, and prior authorization).

For questions about the fees, providers should contact Provider Services at (800) 947-9627. For questions about rates, providers should contact the DHCAA by writing to the following address:

Policy Analyst  
Division of Health Care Access and Accountability  
Community Recovery Services  
PO Box 309  
Madison WI 53701-0309

<b>Maximum Allowable Fees for Community Recovery Services</b>					
<b>Procedure Code</b>	<b>Procedure Code Description</b>	<b>Available Modifier</b>	<b>Contracted Rate</b>	<b>Reimbursement (Federal Share) Paid 7/1/12 Through 9/30/12*</b>	<b>Maximum Allowable Fee (Federal Share) Effective on and After 10/1/12*</b>
H0038	Peer Services, per 15 minutes	TU (Travel Time)	\$9.78	\$5.92	\$5.84
H0043	Community Living Supportive Services	U9 (Per Diem) U8 (Periodic) TU (Travel Time)	\$125.00 per diem \$5.00 periodic (15-minute increments)	\$75.66 per diem \$3.03 periodic	\$74.68 per diem \$2.99 periodic
H2023	Supported employment, per 15 minutes	TU (Travel Time)	\$11.51	\$6.97	\$6.88

\* Counties actually receive five percent less than the maximum allowable fee. The Department of Health Services is authorized by state statute to retain five percent of the federal financial participation funds to cover the administrative costs of operating the Community Recovery Services benefit.



**Overview of Community Recovery Services and  
Comprehensive Community Services (A8)**

**The following is an overview of how some services are billed.  
Community Recovery Services (1915i)  
EXCERPT: ForwardHealth Provider Information, October 2010, No.  
2010-94 p.10 Peer Support**

Individuals trained and certified as peer specialists serve as advocates and provide information and peer support for members in outpatient and other community settings. All members receiving 1915(i) peer-support services will reside in home and community settings. Certified peer specialists perform a wide range of tasks to assist members in regaining control over their own lives and over their own recovery process. Peer specialists function as role models demonstrating techniques in recovery and in ongoing coping skills through:

- (a) Offering effective recovery-based services;
- (b) Assisting members in finding self-help groups;
- (c) Assisting members in obtaining services that suit that individual's recovery needs;
- (d) Teaching problem solving techniques;
- (e) Teaching members how to identify and combat negative self-talk and how to identify and overcome fears;
- (f) Assisting members in building social skills in the community that will enhance integration opportunities;
- (g) Lending their unique insight into mental illness and what makes recovery possible;
- (h) Attending treatment team and crisis plan development meetings to promote member's use of self-directed recovery tools;
- (i) Informing members about community and natural supports and how to utilize these in the recovery process; and
- (j) Assisting members in developing empowerment skills through self-advocacy and stigma-busting activities.

Each contracted CRS provider (i.e., the service provider with whom the Medicaid-certified county or tribal provider contracts for the provision of CRS) is required to complete the CRS Benefit Provider Agreement and Acknowledgement of Terms of Participation form, F-00312 or F-00312A. The Medicaid-certified CRS county or tribal provider shall retain such forms and renew them periodically as required. All Medicaid-certified CRS county and tribal providers and contracted providers are required to follow all policies and procedures in the Online Handbook.

**Service Limits**

**Daily and monthly service limits for the CRS are as follows:**

- Peer Supports — Up to eight hours (32 units) per day and 40 hours (160 units). A unit is equal to 15 minutes. Service limits are for delivery time only and do not include travel time.

### **Community Recovery Services Rate Information**

HCPCS H0038 Peer services, per 15 minutes = \$9.78

#### **Documentation of Peer Support Services in CRS**

The expectation is that a written progress record, signed and dated by the rendering provider and clearly identifiable as relating to the individual member, will be created. For each DOS for which a Medicaid claim is submitted, this record shall reflect which services, as enumerated in the member's ISP, were provided to the member. The record shall also provide a clear indication that such services were rendered with a sufficiency of time as to substantiate the reimbursement requested. The record must reflect the outcome of the service rendered (i.e., it must be clear from the documentation that services are provided with ISP outcomes in mind, including status and process). Documentation must support how the provider addressed any health and safety needs of the individual, including completing incident reports and outcomes. Incident reports are to be submitted to the county/tribe case manager for review and action as described in the SPA Quality Improvement Strategy. Finally, if travel is to be claimed, the expectation is that providers will keep detailed travel records in a contemporaneous manner to support the time claimed.

### **Comprehensive Community Services DHS 36**

#### **CCS Definition of Peer Specialist--Excerpt from DHS 36: 36.10**

A peer specialist, meaning a staff person who is at least 18 years old, shall have successfully completed 30 hours of training during the past two years in recovery concepts, consumer rights, consumer-centered individual treatment planning, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, consumer confidentiality, a demonstrated aptitude for working with peers, and a self-identified mental disorder or substance use disorder.

#### **Rate Information**

CCS is a cost-based service with rates determined by the County program operating the CCS. Peer Specialist services are billed to Medical Assistance based on the County program's CCS service array and actual cost of the service.

#### **Service Titles**

Within the CCS Service Array, several services may be provided by a Peer Specialist including service facilitation. The CCS service titles with State definitions listed below readily incorporate peer support.

#### **Recovery Education and Illness Management**

Recovery education and Illness management are a broad set of strategies that promote hope, healing and empowerment. These strategies are designed to help individuals manage their illness, reduce their susceptibility to the illness, cope effectively with symptoms, identify supports that are effective, and advocate for receiving those supports. Major activities may include:

- Individual skills/illness self-management training – focus on recovery training where outcome is to give the consumer self-assessment skills, and includes interventions such as modeling, role-playing, practice, homework, shaping and reinforcement. Community activities which focus on decreasing the symptoms of mental illness through various wellness activities. May include one-to-one therapeutic support, including supportive activities.

- Counseling – Oriented toward problem solving and supportive activities provided in individually and in groups for consumers and their families to engage in recovery-based activities at home and in the community. Teaching individuals how their thinking styles and beliefs influence their feelings, and helping them to evaluate and change thoughts that lead to depression, anxiety, and anger. Includes cognitive-behavioral strategies to reduce severity and distress of persistent symptoms and promote personal insight within a group dynamic

Support to develop a crisis plan – includes identification of early warning signs of crisis and details about preferred supports.

### **Community Skills Development and Enhancement**

Problem solving, support, training, assistance, and cuing related to functional living skills to assist the consumer to gain and utilize skills related to personal hygiene, shopping, laundry, benefit education, household tasks, money management, how to access transportation, medication adherence, parenting, independent living problem solving, self-management, connection to community resources, social skill development, and other day to day requirements of living. May be provided in a one-to-one or group intervention, including supportive activities. May include one-to-one therapeutic support to ensure that a consumer acquires the skills needed to attain independence.

### **Communication and Interpersonal Skills Training.**

Specific skill training in communication, interpersonal skills, problem solving, conflict resolution, assertiveness, and other specific needs identified within the consumer's functional assessment. Individual or group interventions, including supportive activities, to increase social connections and meaning, and to improve communication skills and comfort in interpersonal relationships.

As programs covered by Medicaid, the standards for documentation in CCS are consistent with those listed under CRS. The services must be consistent with the individual's needs, service plan, and be authorized by a Mental Health Professional.

### **Other Considerations:**

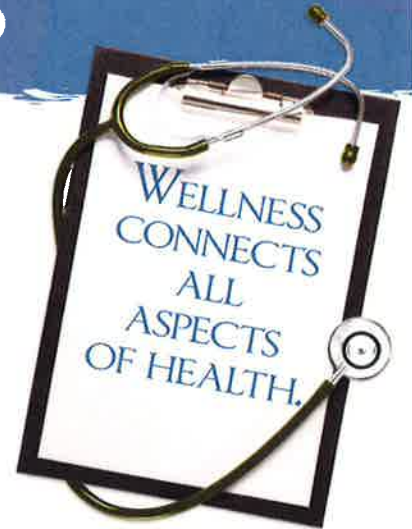
Note that the individual must have Medical Assistance coverage and meet income limits to be eligible to apply for CRS. Individuals who do not have MA, and thus do not qualify for CRS, cannot receive Peer Support services through CRS. CRS is a benefit program that covers three specific services only—Peer Support, Supported Employment, and Community Living Supportive Services.

“Peer Support” is an identified service type in CRS but it is not one of the service titles on the CCS model array. Peer support is a service that is incorporated within the groupings of service titles used in CCS programs. Eligibility for CCS differs from CRS. Medical Assistance coverage is not a requirement for eligibility in CCS.

## **SAMHSA's Eight Dimensions of Wellness (A9)**

# SAMHSA'S WELLNESS INITIATIVE

## Eight Dimensions of Wellness



### EMOTIONAL

Coping effectively with life and creating satisfying relationships.

### ENVIRONMENTAL

Good health by occupying pleasant, stimulating environments that support well-being.

### FINANCIAL

Satisfaction with current and future financial situations.

### SOCIAL

Developing a sense of connection, belonging, and a well-developed support system.

### INTELLECTUAL

Recognizing creative abilities and finding ways to expand knowledge and skills.

## WELLNESS

### PHYSICAL

Recognizing the need for physical activity, diet, sleep, and nutrition.

### SPIRITUAL

Expanding our sense of purpose and meaning in life.

### OCCUPATIONAL

Personal satisfaction and enrichment derived from one's work.

Communication among mental health consumers, professionals, and primary care providers about health information is essential to overall wellness.

Through its Wellness Initiative, SAMHSA pledges to promote wellness for people with mental and substance use disorders by motivating individuals, organizations, and communities to take action and work toward improved quality of life, cardiovascular health, and decreased early mortality rates.



To learn more and sign the Pledge for Wellness, visit <http://www.samhsa.gov/wellness>.

For information, contact: SAMHSA's Wellness Initiative  
1 Choke Cherry Road  
Rockville, MD 20857  
E-mail: [wellness@samhsa.hhs.gov](mailto:wellness@samhsa.hhs.gov)

\*Source: Swarbrick, M. (2006). A wellness approach. *Psychiatric Rehabilitation Journal*, 29(4), 3311-3314.

**We've Hired Peer Specialists-Now What?**  
**Janis Tondora, Psy.D.**  
**Yale University (A10)**

## We've Hired Peer Specialists - Now What?:



### Common Questions and Concerns Involved in Employing Persons In Recovery

Janis Tondora, Psy.D.

5<sup>th</sup> Annual Mental Health and Substance Abuse Training Conference  
October 26, 2010

## Our intent today...

- Typical "hot button" concerns re: legal/personnel issues
- Strategies for promoting an inclusive workplace ("bare min" legal expectations + spirit of recovery-oriented care)
- Where to go for further info/assistance

## Mental Illness is NOT a Full-time Job:



"Well, this is a very impressive resume', young man. we think you are going to make a fine patient."

## The Power of "Peer Services"

*"The peer-to-peer model is an exceptional example of the innovative ways in which we can help the system overcome its own barriers. Peer-support programs are not just empowerment programs.*

*They are an expression...and an example...of the way the system is going to have to fundamentally change to foster healing relationships, and create an environment conducive for recovery."*

➤A. Kathryn Power, CMHS





## What are some gifts Peers can offer?

- Instillation of hope
- Role modeling recovery
- Mentoring
- Engagement
- Street Smarts
- Education

## Hope Embodied in Another...

It would have greatly helped to have had someone come and talk to me about surviving mental illness—as well as the possibility of recovering, or healing, and of building a new life for myself. It would have been good to have role models—people I could look up to who had experienced what I was going through—people who had found a good job, or who were in love, or who had an apartment or a house of their own, or who were making a valuable contribution to society.

Deegan (1993)

## Voices of Person-Centered Recovery




## Been there... Done That Before Now



**Who is a Recovery Mentor?**


Someone who:

- Has personal experience receiving mental health services
- Wants to give back to others in recovery
- Has been trained to protect your confidentiality and your rights as a research participant
- Is dedicated to your recovery



**Recovery Mentors**


Partners in Your Recovery!



**What does a Recovery Mentor do?**

A Recovery Mentor can:

- Get to know you and the things that are important to you and your recovery
- Encourage you to speak up about your priorities and goals
- Help you figure out how your team can best support you
- Point you to resources in your community
- Help you work with your team to create a "person-centered" plan




Your Recovery Mentor: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Who is a Community Connector?**


A Community Connector is someone who:

- Has personal experience receiving mental health services
- Wants to give back to others in recovery
- Has received training in protecting your confidentiality and your rights as a research participant
- Is available to help you reconnect with things you like to do in the community



**Community Connections Program**

Getting Out & About in Your Community!



**How can I make use of this program?**

You can:

- Get to know your local community and all it has to offer you
- Have leaders or others accompany you on fun and interesting community outings
- Connect to people, places, and things where you feel welcomed and valued

Community Connector: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Voice of a peer**

▶ "What was really important was that participants were empowered to take charge of their own [treatment] plans. They would emerge with more confidence, and for the most part a more meaningful and useful relationship with their clinicians...I've learned and grown as have the people I've worked with...[t]he experience has been humbling and rewarding at the same time."

• Jim, Recovery Mentor (2008)

**Ideally...**

▶ In an ideal world, we could all provide peer support based on our life experiences – we do it every day – different issues, but similar results.

▶ Defining Peer Support:

- A person in recovery and or a person with lived experience who offers services and supports to other people in recovery (Davidson, 2006)
- A system of giving and receiving help based on values of respect and mutual agreement...not based on "traditional" psychiatric models (Mead, 2001)

## Complex “Hot Button” Issues

- ▶ Lunch room conversations – peer staff getting left out
- ▶ Keys – who holds the keys?
- ▶ Boundaries – setting limits
- ▶ Case-management vs Peer Support
- ▶ Access to medical records/confidentiality
- ▶ Supervision vs. therapy
- ▶ “reasonable” accommodations
- ▶ Job security; Career mobility



## “Bare minimum” legal expectations

- Rehab Act of 1973
- Family and Medical Leave Act (1993)
- ADA, Title 1
  - Provides the most extensive guidance re: employer expectations both pre and post-hire
  - “Reasonable accommodations”
  - There is no “covered” list - does the person have an “impairment that substantially limits one or more major life activities, a record of such an impairment, or is regarded as having such...”

## Pre-hire Issues for Consideration

- **How do we word handle advertisements/postings in assertive outreach to PIRs?**
  - EEOC advises employers to include information about the “essential functions” of the job
  - **\*For peer-based positions:**
    - Allowable to “screen-in” if lived experience is an essential function.
    - “As one who has availed themselves of mental health services, the CP will share their own experiences and what skills, strengths, supports, and resources they use. As much as possible, the CPs will share their own recovery stories and will demonstrate how they have directed their own recovery processes.”
  - **For varied positions:** Include non-discrimination clause

\*Chinman, et al., 2008. *Mental Health Consumer Providers: A Guide for Clinical Staff*. RAND Corporation.

## Pre-hire Issues for Consideration

- **What about interview and application ??s?**
  - **For peer-based positions:**
    - Allowable to inquire re: EF and if individual can meet expectations, e.g., RM recruitment
  - **In general:**
    - **Note:** may ask medical/disability-related ?s AFTER a conditional job offer has been made – only if required of all employees in that job category and if relevant to EF
    - Pre-hire can NOT ask ??s that are likely to elicit information about a disability...

Job Accommodations Network: <i>Pre-Offer, Disability-Related Questions: Dos and Don'ts</i> . See: <a href="http://www.jan.wvu.edu/media/preofferfact.doc">http://www.jan.wvu.edu/media/preofferfact.doc</a> .	
<b>Job Performance</b>	
<b>DO</b>	<b>DON'T</b>
-Are you able to perform the essential function of the job you are seeking, with or without accommodations?	-Do you have any physical or mental impairment that would keep you from performing the job you seek? -What physical or mental impairments do you have that would affect your job performance?
<b>Attendance Requirements</b>	
<b>DO</b>	<b>DON'T</b>
-Can you meet our attendance requirements? -How many days were you absent from your last job? -How many Mondays were you absent last year or leave other than approved vacation leave?	-How many days were you sick during your last job?
<b>History of Injury</b>	
<b>DO</b>	<b>DON'T</b>
-How did you break your leg?	-Do you break bones easily? -Do you expect the leg to heal normally?
<b>Drug Use</b>	
<b>DO</b>	<b>DON'T</b>
-Are you currently using illegal drugs? -Have you ever used illegal drugs?	-What medications are you currently taking? -How often did you use illegal drugs in the past? -Have you ever been addicted to drugs? -Have you ever been treated for drug addiction? -Have you ever been treated for drug abuse?
<b>Alcohol Use</b>	
<b>DO</b>	<b>DON'T</b>
-Do you drink alcohol? -Have you ever been arrested for driving under the influence of alcohol?	-How much alcohol do you drink? -Have you ever participated in an alcohol rehabilitation program?

- ## Post-hire Issues for Consideration
- **Will I need to make special accommodations for the person?**
    - Not necessarily – do NOT assume, e.g., exempted people in past from HIC/IRB
    - Even if performance becomes an issue, may not be disability-related
    - But, if an employee identifies as an individual with a disability, they have a right to request “**reasonable accommodation**”

- ## Reasonable Accommodation
- **What is a “reasonable accommodation?”**
    - Any change in the work environment or in the way a job is performed that enables a person with a disability to enjoy equal employment opportunities.
      - Changes to a job application process
      - Changes to the work environment, or to the way a job is usually done
      - Changes that enable an employee with a disability to enjoy equal benefits and privileges of employment (such as access to training).
      - **This makes sense for people who use wheel-chairs but how does it apply to PIRs?? Stay tuned!**

- ## Reasonable Accommodation
- **How will I know if a person is entitled to such... can I request documentation?**
    - Yes, but focus on the effect of the disability on the job functions, NOT on meds/Hx/Dx
  - **And will I recognize a request for a RA when I see it?**
    - May be in “Plain English”
      - *I have a medical condition that requires breaks every two hours...*
      - *Because of health issues, I need a quiet work space at the back of the office.*

## Reasonable Accommodations

### • So how does this apply to PIRs?...How might the illness interfere?

- Screening out the environment
- Sustaining concentration
- Maintaining stamina (can be side effects)
- Handling time pressures
- Maintaining professional appearance
- Responding to change or unanticipated transitions
- Interacting with others and following social/business norms (can be symptoms or lack of practice!)
- Organizing/prioritizing
- Dealing with negative feedback

## Reasonable Accommodations

### • How can I help as a supervisor/ administrator?

- **Scheduling modifications**
  - Be sensitive to late/early arrival or "standard" schedule to accommodate appointments
  - Offer longer or more frequent breaks
- **Leverage resources (personal and external)**
  - Initial meeting with the worker and those who know him/her well... what types of RAs might be useful and re-evaluate over time.
  - Encourage on-site and/or phone support from supporters
  - Leveraging resources depends on preference of the worker

## Reasonable Accommodations

### • How can I help as a supervisor/ administrator?

- **Provide clarity in expectations**
  - Provide a clear description of expected tasks in writing
  - Minimize changes to this description over time once successful
  - Divide larger tasks into smaller steps
  - Provide advance notice for large projects/deadlines
  - Be flexible with deadlines (to the extent possible)
  - Accept alternative formats for work, e.g., typed/ hand-written/ or recorded notes if submitting written work
  - Consider placement in a cooperative group project so the person can work with the support of a team
- **Environmental considerations**
  - Provide access to a partitioned work space or more private work area
  - Allow use of white noise technology
  - Designate a quiet rest area in your place of business

## Reasonable Accommodations

### • How can I help as a supervisor/ administrator?

- **Expand supervision/coaching**
  - Provide increased supervision (cost-benefit analysis involved)
  - Make use of written to-do lists to assist with prioritization and deadlines
  - Limit supervisor changes over time once successful
  - Incorporate positive feedback in supervision
  - Note: do not automatically "exempt" the volunteer from performance reviews if these are standard across volunteers.
- **Social supports**
  - Designate a co-worker mentor, e.g., Buddy system
  - Be pro-active and offer disability awareness trainings
  - Facilitate (but don't mandate) inclusion in social functions

## Reasonable Accommodations

- An administrative assistant in a social service agency has bipolar disorder. Her duties include typing, word processing, filing, and answering the telephone. Her limitations include difficulties with concentration and short-term memory. Her accommodation included assistance in organizing her work and a dual headset for her telephone that allowed her to listen to music when not talking on the telephone. This accommodation minimized distractions, increased concentration, and relaxed the employee. Also, meetings were held with the supervisor once a week to discuss workplace issues. These meetings are recorded so the employee can remember issues that are discussed and can replay the information to improve her memory.

## Reasonable Accommodations

- **Examples within peer-specific services**
- **Isn't this just good management?**
  - In many ways, YES!!  
Good management sense...
  - **Likely will enhance culture of your workplace as a whole!!**
  - May be particularly useful if an illness is interfering with a worker's ability to perform essential functions



## Reasonable Accommodations

- **Will it cost me an arm and a leg?**
  - JAN research w/ 366 employers shows low-cost, high-impact
    - 46% report NO cost
    - Of employers reporting cost... 45% report one-time expenditure only. Limited in amount
    - 75% reported the RAs were either very effective or extremely effective.
- **Benefits of making accommodations far outweigh the costs!**

## Reasonable Accommodations

- **How do I deal with co-workers perception of "special" treatment for peers?**
  - If it is cost-effective AND good management in general... maybe it shouldn't be SPECIAL!, e.g., inclusive ed
  - From legal perspective:
    - "Need to know" basis... most often peers are disclosed based on definition
    - Otherwise... *Acting in accordance w/employment law, etc.*
    - Be pro-active and make disability a part of the organization's ongoing diversity dialogue!

## Reasonable Accommodations

- **Can I initiate the RA conversation with an employee?**
  - Yes, approach the person directly and privately.
  - Ask how things are going?, how have they been getting along with other staff?, how have they been doing with deadlines?, etc.
  - Share your observations/concerns in a direct/explicit manner.
  - Clearly describe expectations for your place of business
  - Get the worker's perspective
  - Don't put on kid-gloves – balance!
    - Supervision vs. therapy



## Reasonable Accommodations

- **Can we enforce conduct rules?**
  - Yes. An employer never has to excuse a violation of a conduct rule that is
    - Uniformly applied (e.g., verbal altercation)
    - "Consistent with business necessity" (e.g., hygiene/dress)
  - Following disciplinary action, make an effort to provide RA to assist employee in meeting conduct codes in future.
- **Can we fire an employee with a disability who is not doing the job?**
  - Yes. Assuming you have first made attempts to provide RA.
  - Must be able to do the EF functions of the job.

## More Hot Button Issues In Employing PIR

- **How do we handle an applicant who currently receives services HERE?**
  - Preferable for CPs to receive tx elsewhere in order to minimize difficulties w/ dual relationships but... (RAND, 2008)
    - by intentional team assignment/agency role
    - by establishing clear policies re: relationships and limits (e.g., romantic, financial, etc.)
    - by providing ongoing supervision
    - by educating other employees about recovery process; "value-added" of peer-based services
    - by giving staff opportunity to openly discuss concerns/questions without being labeled as anti-peer

## More Hot Button Issues In Employing PIR

- › **Will peer staff be able to handle the pressure?**
  - › Personal challenges – sustaining personal recovery and well-being while doing the work (applies to all staff!)
    - › Mentoring Mentors; Supervision/Co-Supervision
- › **What do we do if a peer-staff member relapses?**
  - › The same thing you would do with any other employee experiencing a health crisis!
  - › Normalize the ongoing use of services (including the hospital) as part of recovery process, e.g., peer ER

## More Hot Button Issues In Employing PIR

### › What exactly are peers expected to do?

- › Importance of role clarity, i.e., mini-case manager vs. Peer Specialist – what is the value added?
- › Benefits of concrete/practical contributions to team

### › How do we maintain confidentiality?

- › Peer staff access to records...keys, charts, etc.
- › Beware the red herring!



## Where do I go for more information?

- Don't forget about "close-to-home" resources
  - Peer-based orgs, consumer councils, employee him/herself
  - Central office vocational and peer-services
  - Department of VR/BRS
  - Local EEOC, P&A, Disability Rights Centers
- Web-based resources available at:
  - National Center on Workforce and Disability
  - Job Accommodations Network
  - Boston Center for Psychiatric Rehabilitation

## A Take Home Message

- We have certain legal mandates but hiring PIRs simply makes good BUSINESS sense
  - ...promotes diversity in skills and talents
  - ...is an emerging evidence-based practice leading to better outcomes
  - ...is consistent with our transformation values/mission!!
- **LEAD BY EXAMPLE!!**



