

Representation through Lived Experience: Expanding Representative Bureaucracy Theory

Cullen C. Merritt
Paul H. O'Neill School of Public and Environmental Affairs
Indiana University-Purdue University Indianapolis
merritt1@iupui.edu

Morgan D. Farnworth
School of Public Affairs and Administration
University of Kansas
mfarnworth@ku.edu

Sheila Sues Kennedy
Paul H. O'Neill School of Public and Environmental Affairs
Indiana University-Purdue University Indianapolis
shekenne@iupui.edu

Gordon Abner
Lyndon B. Johnson School of Public Affairs
University of Texas at Austin
gordon.abner@austin.utexas.edu

James E. Wright II
Reubin O'D. Askew School of Public Administration and Policy
Florida State University
jwright4@fsu.edu

Breanca Merritt
Paul H. O'Neill School of Public and Environmental Affairs
Indiana University-Purdue University Indianapolis
breanca@iupui.edu

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ABSTRACT

This study draws on the insights of managers in the behavioral health treatment system to explore the value of persons who bring lived experience to their organizational positions. Within these organizations, persons with relevant lived experience occupy various nonclinical and clinical positions. When facilities incorporate workers with lived experience, managers observe increased levels of trust between clients and service providers, an enhanced client-centered perspective among service providers, and higher quality in the services provided. This study may guide managers in considering how (or whether) human service organizations might institutionalize lived experience as a mechanism to help create a representative bureaucracy.

PRACTICE POINTS

- In the behavioral health treatment system, the use of peer-provided services demonstrates an organization's commitment to engaging with and learning from the experiences of former service recipients.
- Employees who have experienced the challenges an organization addresses introduce distinct, relevant knowledge that cannot be replicated through education and training.
- Active representation on the basis of lived experience is neither inherent nor automatic and is influenced by institutional and contextual factors.
- In the behavioral health treatment system, organizations reduce challenges associated with integrating workers with lived experience by clearly defining roles and responsibilities, education and training, formal supervision and monitoring processes, and policies/rules that outline clear boundaries between persons with lived experience and clients.
- If care is taken to develop roles and job descriptions that make thoughtful and appropriate use of workers with lived experience, organizations may improve their capacity to serve their clientele.

INTRODUCTION

As the United States population has become more diverse, the calls for a public sector that “looks like” America has steadily grown (Elias 2013; Krislov & Rosenbloom 1981; Selden 1997; Sowa & Selden 2003). In addition to the various tangible benefits of a more representative public sector that scholars have identified, a bureaucracy that is broadly representative of its constituency should theoretically be equipped to ameliorate some of the tensions generated by vague public policies or even an unresponsive democratic government (Capers 2018; Long 1952; Kellough 1990a; Kellough 1990b; Sowa & Selden 2003). A commitment to creating a representative bureaucracy, however, requires an interpretation of what constitutes representation: what characteristics should be represented in such a bureaucracy? What does it mean to advocate for government representatives who *are* representative? What identities and attributes appropriately mirror the population being served?

To date, the substantial corpus of scholarly research into passive (or symbolic) and active (or substantive) representation has focused almost entirely upon the immutable demographic characteristics—identities such as race and ethnicity, gender, and sexual orientation—that affect public servants’ socialization and participation in government. Underexplored, however, is the extent to which an individual’s identity and subsequent participation in bureaucracy can be attributable to their *lived experience*, or their interactions with an idiosyncratic environment, including those that have formed their worldview and attitudes. In behavioral healthcare, the concept of lived experience recognizes that personal understanding of certain forms of trauma related to mental health and substance use disorders may affect the formation of individual identity, which is a product of life experience and not exclusively biological or genetic factors.

The majority of states in the U.S. have established programs that train and certify persons with relevant lived experience, often referred to as peer support workers (PSWs), to formally support others along their path to recovery within organizational settings (Kaufman et al. 2012; Myrick & del Vecchio 2016). Most recently, service delivery models incorporating persons with lived experience have proliferated in behavioral health treatment facilities to assist clients facing opioid addiction (Gagne et al. 2018; McGuire et al. 2020; Samuels et al. 2018; Waye et al. 2019), offer social and emotional support for individuals with histories of homelessness (O’Shaughnessy & Greenwood 2020), and is considered a potential means for improving the mental wellbeing of COVID-19 patients (Torous et al. 2020; Nobles et al. 2020). Public administration and human service organizations research, however, are largely silent on how organizations identify and utilize employees’ lived experience, if there are organizational consequences associated with integrating persons with lived experience, and what theoretical linkages exist between lived experience and representative bureaucracy. This study is an effort to address that silence by employing a multiple case study analysis to answer two questions about managers’ perceptions of lived experience in the context of behavioral health treatment: (1) what organizational roles are appropriate for persons who have lived with (or experienced) the challenges the agency is charged with addressing? and (2) what are the implications of integrating persons with lived experience into organizational roles within treatment facilities?

In this study, we first review the literature on representative bureaucracy. Second, we provide the theoretical framework for our study, which lies at the intersection of lived experience and identity theory. Third, we describe the study’s data and methodology. Fourth, we report findings on the roles and implications of integrating persons with lived experience into the

organizational fabric. We conclude by discussing theoretical contributions and practical implications of this research as it relates to representative bureaucracy.

REPRESENTATIVE BUREAUCRACY

As one of the most heavily analyzed concepts in public administration, *representative bureaucracy* suggests that bureaucratic power used to enforce public policy is made more responsive to public interests when bureaucrats represent a “cross section of American society” (Selden 1997, xiii), particularly in terms of race, ethnicity, gender, and social class (Selden 1997; Mosher 1982; Meier 1975). According to Bishu and Kennedy (2019), studies on ethnicity and race have been most prevalent, with a growing number of studies highlighting the importance of gender and sexual identity. Introduced by Kingsley (1944), representative bureaucracy finds that public servants, particularly street-level bureaucrats who interact most directly with citizenry (Lipsky 2010), exercise discretion in ways that benefit underrepresented segments of society, especially those with whom the bureaucrat identifies (Selden 1997; Brudney et al. 2000). As the final policy implementers, street-level bureaucrats produce policy as citizens experience it (Meyers & Vorsanger 2007; May & Winter 2009; Keiser 2010) and exercise considerable discretion in the provision of public services. Literature has shown that these bureaucrats occupy roles like educators/teachers (Grissom, Nicholson-Crotty & Nicholson-Crotty, 2009; Meier & Stewart, 1992; Pitts 2007; Taylor 2007), law enforcement officers (Hong, 2016; Meier and Nicholson-Crotty 2006; Wilkins and Williams 2008; Wright and Headley 2020), health care personnel (Walker and Gibson 2004; Wells 2007), and social service providers (Wilkins and Keiser 2006; May and Winter 2009; Keiser 2010).

While early empirical research on representative bureaucracy considers representation as a function of social class, age, and income (Mosher 1982; Meier 1975; Kingsley 1944), more recent literature examines representation with respect to race and ethnicity (Hong 2016; Grissom et al. 2009; Wilkins & Williams 2008; Meier 1993), gender (Ricucci et al. 2016; Ricucci et al. 2014; Meier & Nicholson-Crotty 2006; Keiser et al. 2002), and sexual orientation (Wald et al. 2002; Thielemann & Stewart 1996), among other identities (e.g. veteran status, see Gade & Wilkins 2012). At a minimum, greater representation of underrepresented groups within an organization implies a symbolic commitment to equal access to decision-making and power (Gallas 1985; Meier 1993; Mosher 1982). Particularly as it relates to race, passive representation may also shape the way in which the public perceives and responds to government (Theobald & Haider-Markel 2008; Overby et al. 2005; Banducci et al. 2004). Moreover, a representative bureaucracy confers substantial benefits to both the organization and the broader society (Lim 2006; Selden 1997), including an infusion of new expertise into the organization (Kranz 1976), more accurate reflection of group policy preferences (Dolan 2002; Meier & Nigro 1976), a greater inclination for marginalized populations to interact with government (Shafritz et al. 1986; Kranz 1976), and tangible benefits conferred to the group a bureaucrat represents (Andrews et al. 2014; Selden 1997; Meier 1993). For example, Meier and Nicholson-Crotty (2006) find that police departments with more female officers experience higher rates of sexual assault reports and subsequent convictions. Further, Thielemann and Stewart (1996) demonstrate that AIDS treatment recipients are better served and more satisfied when the bureaucrats with whom they interact have diverse sexual orientations. In a particularly substantive finding, Meier and Bohte (2001) conclude that the presence of minority teachers, when those teachers are able to act with

discretion, is associated with better student outcomes for *both* minority and nonminority students.

Representative bureaucracy posits that *passive representation*, or the extent to which a bureaucracy employs individuals of diverse backgrounds, can lead to *active representation*, or the implementation of policies that reflect the interests of such diverse groups (Selden 1997; Hindera 1993; Meier 1993; Mosher 1982; Meier & Nigro 1976; Pitkin 1967). The ability to translate passive into active representation depends on the salience of the represented identity and the level of discretion exercised by a bureaucrat (Sowa & Selden 2003; Keiser et al. 2002; Selden 1997). Recently, scholarship has suggested that symbolic representation is a mechanism in which the identities of bureaucrats can induce certain behaviors of citizens or clients without any substantive action by the bureaucrat (Bradbury and Kellough 2011; Theobald and Haider-Markel 2009).

The relationship between passive and active is mediated, in part, by organizational socialization, or the process of infusing organization-specific norms and values into employee perceptions and behaviors (Wilkins & Williams 2008; Riccucci & Meyers 2004; Keiser et al. 2002; Selden 1997). That is, the overarching mission and culture of an organization, in some instances, may be a stronger determinant of bureaucratic action than individual identity, particularly when an organization's mission or culture does not emphasize interests of minorities (Selden 1997; Meier & Nigro 1976). For example, Wilkins and Williams (2008) demonstrate that a greater proportion of African American police officers are unexpectedly associated with increased complaints of racial profiling in policing by African American drivers. Their analysis asserts that "the pressure to conform to the organization or to achieve the goals of the organization weighs heavily on black officers and affects their attitudes and ultimately their

behavior” (Wilkins and Williams 2008, 660–1). Simply put, passive representation does not uniformly lead to active representation; instead, this translation depends significantly on the larger organizational culture, and must be cultivated and supported by leadership, external pressures, and organizational structure.

THEORETICAL FRAMEWORK

The growing research into representative bureaucracy, both passive and active, focuses almost entirely on immutable demographic characteristics, such as race and ethnicity (e.g., Watkins-Hayes 2011; Wilkins & Williams 2008), gender (e.g., Keiser et al. 2002; Meier & Nicholson-Crotty 2006), and sexual orientation (e.g., Lewis & Pitts 2009; Thielemann & Stewart 1996). However, individuals who experience trauma, mental illness, or substance use disorders may build individual identities based more on those lived experiences than on the effects of biological or genetic factors (Vandewalle et al. 2018; Dubin-McKnight 2015; Gruhl et al. 2015). These issues—which emerge at the intersection of lived experience and identity theory—are especially salient in behavioral healthcare treatment facilities and give rise to the active representation of recipients of these services.

Lived Experience

Behavioral health organizations offer treatment and recovery support for clients coping with illnesses which include “a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities” or “occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.” (Substance Abuse and Mental Health Services Administration 2020).

Due to the individualized nature of behavioral health, this social service domain interacts almost exclusively with adaptive challenges, or problems “not amenable to authoritative expertise and standard operating procedures. [These challenges] cannot be solved by someone who provides answers from on high” (Heifetz & Linsky 2002, 13; Merritt 2019b). Because of this reality and in response to calls for patient empowerment and a culturally competent workforce that understands the needs of the target population (Substance Abuse and Mental Health Services Administration 2016), behavioral health treatment facilities have “pioneered efforts to incorporate staff members with lived experience into recovery models, treatment plans, and other features of policy implementation” (Merritt 2019b, 153; see also Stratford et al. 2017; Myrick & del Vecchio 2016; Repper & Carter 2011; Tomes 2006). This model of service delivery allows individuals to leverage their lived experience as former service recipients—alongside formal training—as a resource that qualifies them to engage in providing client care and educating other workplace professionals (Crane et al. 2016; Byrne et al. 2013; Bradstreet 2006; Dennis 2003; Merritt 2019b). Engaging persons with lived experience in this work thus focuses on their strengths—rather than on their prior illnesses—and engages their unique perspectives to complement clinical models (Myrick & del Vecchio 2016; Repper & Carter 2011; Moll et al. 2008; Merritt 2019b). In behavioral health treatment services, in fact, including persons with lived experience “in matters as diverse as service delivery, policy formation, participation in interview panels, and the development of new models of care has evolved from its somewhat tokenistic foundations to become an expectation” (Byrne et al. 2013, 196).

Identity Theory

Identity theory is premised on the idea that individuals take on identities that are dependent upon (1) their social interactions with other individuals and (2) the specific environments in which

these interactions occur (Dubin-McKnight 2015; Hogg et al. 1995; Meier 2018; Stets & Burke 2000). When an employee with lived experience interacts with current clients in the behavioral health treatment system, that employee's identity becomes linked to and validated by their previous illness and prior status as a patient (Dubin-McKnight 2015; Repper & Carter, 2011). More specifically, their identity as a service provider cannot be fully activated without simultaneously calling up another fundamental identity—(former) patient—“as peer-employees must utilize their [prior] experiences as a recipient of services in their daily work activities, *and their employment is contingent on their patient status*” (Dubin-McKnight 2015, 16; italics added). Furthermore, “the more an individual interacts with the same group or network, and invokes the same identity, the more integrated that identity is in that person. For someone with a psychiatric disability, their length of time in, and exposure to the mental health system may have greater implications on their ‘patient identity’ than someone who has had less time and exposure to the mental health system” (Dubin-McKnight 2015, 15). In fact, identity theory suggests that persons with lived experience may pursue opportunities in which “patient” and “worker” identities are collectively evoked because those identities—and the resulting ability to uniquely “represent” and help advance the recovery of current clients—offer the greatest rewards (Dubin-McKnight 2015; Smith-Lovin 2003).

Commenting on the active representation frequently achieved by persons with lived experience, Dubin-McKnight (2015) posits that “the involvement of peer-employees in traditional mental health systems increases positive outcomes for recipients of services because of the peer-employee's receptiveness and efforts made to reduce the power imbalances inherent in service provision” (24). However, evidence of the effects associated with peer support services is largely mixed (Park 2019; Myrick & del Vecchio 2016; Bassuk et al. 2016; Lloyd-

Evans et al. 2014; Davidson et al. 2006). Several studies find positive client outcomes, including reduced hospitalizations and inpatient service use (Chinman et al. 2014; Landers & Zhou 2011; Repper & Carter 2011; Lawn et al. 2008), patient empowerment (Leamy et al. 2011; Chinman et al. 2008; Resnick & Rosenheck 2008; Corrigan 2006), medication compliance and engagement in treatment (Sells et al. 2006; Solomon and Draine 1995; O'Donnell et al. 1999), nonclinical outcomes related to employment, housing, and education (Laudet & Humphreys 2013) and social support (Felton et al. 1995). Additionally, empirical evidence suggests that integration of peer support services also confers benefits on the peer support workers themselves (Park 2019; Salzer & Shear 2002) as well as to non-peer staff (Chinman et al. 2008), while also allowing organizations to realize cost savings (Solomon 2004; Trachtenberg et al. 2013).

The literature also identifies challenges and risks to integrating peer support services in these organizations. Those challenges include a lack of acceptance by clinical staff (Byrne et al. 2019; Gruhl et al. 2015; Gillard et al. 2013; Walker & Bryant 2013; Chinman et al. 2008), inadequate or complex funding sources (Gagne et al. 2018), concerns regarding a lack of professionalism and blurred or inappropriate boundaries with clients (Gillard et al. 2013; Walker & Bryant 2013; Colson & Francis 2009; Mead & MacNeil 2006), vicarious trauma and re-victimization of peers (Park 2019), and stigma toward peer support workers (Park 2019; Byrne et al. 2019; Mowbray et al. 1998). The growing use of peer support services in behavioral health treatment facilities—and the lack of consensus in the literature surrounding its effects on service provision—indicates the need for further investigation of lived experience as a form of representation in such organizations.

METHODOLOGY

The study team consisted of six researchers spread across four universities, two of whom participated in the research design and data collection and all of whom contributed to data analysis and interpretation. A research assistant assisted with scheduling interviews and transcribing qualitative data. This study is part of a larger ongoing study of the structure, design, and management of behavioral health treatment facilities.

This study uses a multiple case study approach prescribed by Yin (2014) to draw on the insights and attitudes of senior managers to explore the specific organizational roles and perceived effects of employees with lived experience within behavioral health treatment facilities¹. Managers operating in the behavioral health treatment system are arguably the best equipped to analyze the salience of lived experience to their organizations' mission and performance objectives (Merritt 2019b). These managers are best positioned to determine which organizational positions would appropriately integrate lived experience; to identify the implications of this service delivery model for key organizational stakeholders (e.g., middle managers, physicians, personnel with lived experience, clients); and to pinpoint the structural mechanisms their organizations can employ to avoid or overcome challenges associated with the employment of personnel with lived experience. Despite that, relatively few studies have explored the broader implications of a service delivery model incorporating lived experience, nor investigated the perceptions of managers, who are in a position to provide strong (if not the strongest) evidence of organizational realities (Anderson and Paine 1975; Child 1972; Day & Nedungadi 1994; Stazyk & Goerdel 2010; Weick 1969; Merritt 2019a).

¹ Managers' perceptions were influenced by other roles/people in the organization who have lived experience. The managers themselves did not have relevant lived experience as it related to the current study.

By aiming for analytic generalization (rather than statistical generalization) when exploring the interpretive realities of managers in organizational settings (LeRoux et al. 2019), the multiple case study approach allows for a thick description of the phenomenon under study. In particular, this method enabled the researchers to observe the most salient issues related to lived experience—and specifically its consequences for representative bureaucracy—enriched with quotes from the conducted interviews on study participants’ otherwise unobtainable views, feelings, and actions that outsiders might assume about this social services sphere (see Charmaz 2006; Hussein et al. 2004). The employed methodology follows new and established streams of research in the human service organizations context that have used the multiple case study approach to explore a myriad of questions, such as those related to informal accountability in human service networks (LeRoux et al. 2019), the impact of the service system in transforming human service agencies (Vito 2017), and organizational employees’ and leaders’ perspectives on the effects of undergoing accreditation (Lee 2014). Moreover, a recent meta-review of the representative bureaucracy literature by Bishu and Kennedy (2019) found that qualitative studies of representative bureaucracy are limiting our ability to “uncover how and why representation processes yield outcomes” (p. 23).

We describe the current study’s case selection, data collection, and data analysis procedures below.

Case Selection

We initiated case selection by accessing a list of the organizations included in the Behavioral Health Treatment Facility Locator (“Locator”), an online repository for locating treatment facilities. The Locator is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the US Department of Health and Human

Services. Upon retrieving this list, we solicited participants (i.e., senior-level managers) from the Midwest, one US census region with a high concentration of substance abuse disorders and fatalities (Jones et al. 2017; Unick & Ciccarone 2017).

A total of 26 senior-level managers of treatment facilities (e.g., president and CEO, chief operating officer) participated in in-depth interviews over a seven-month span. Table 1 provides summary statistics of participants' backgrounds and the heterogeneous environments within which participants managed their facilities. The sample size of this study is consistent with the recommended number of participants interviewed for a single qualitative study (Beitin 2012; Thomas & Pollio 2002; Creswell 1998; Boyd 2001; Merritt, Kennedy, and Kienapple 2019). According to Beitin's assessment of qualitative research sample standards, "Thomas and Pollio (2002) suggest that an appropriate sample size for phenomenological research can range from 6 to 12 participants...Creswell (1998) recommended between 5 and 25 participants, with another researcher (Boyd 2001) prescribing a more flexible range of 2-10" (p. 243-244).

[Table 1 about here]

Data Collection

We collected data through open-ended, semi-structured telephone interviews. The first phase of interviews involved 16 managers and occurred from January 2017 to March 2017. The second phase of interviews included 10 managers and occurred from June 2017 to August 2017. For the first phase, we employed an approach to data collection in which the knowledge and experiences of the senior managers exclusively guided the emerging themes with respect to the organizational roles and implications of employees with lived experience.

The period between the first and second phases of interviews provided time for the research team to process the first phase of interview data. The second phase of interviews, while

open to fresh insights, was more targeted; we aimed to confirm emerging themes that had surfaced during the first phase of interviews. The semi-structured format used in the second stage helped us explore questions that had been raised during the first phase.

Interviews, across both phases, averaged approximately 60 minutes. For each interview, we recorded and later transcribed the responses verbatim prior to coding and analysis. Interview questions were designed to elicit information about the procedures and roles through which treatment facilities, according to their managers, integrated persons with lived experience into the organization as well as about the effects of such incorporation on the organization. Collectively, the interview questions enabled us to gain insight into (1) the range of organizational and environmental conditions that motivated managers, the principal strategic decision makers in treatment facilities, to employ individuals who had lived with the problems their agencies are charged with addressing; (2) the primary organizational roles and responsibilities taken on by persons with lived experience; (3) any legal, organizational or environmental barriers that prevented treatment facilities from utilizing persons with lived experience; (4) management strategies, specifically the organizational processes, activities, and institutions associated with effectively integrating employees with lived experience; and (5) the effects of personnel with lived experience on key stakeholders and on identified organizational objectives.

The prompt questions used for this study (listed in the Appendix) were asked of all respondents, although the semi-structured format of interviews resulted in variation in the informant-driven discussions and follow-up interview questions.

Data Analysis

To conduct data analysis of the first phase of interviews, multiple researchers participated in a process of open coding (Strauss 1987) to identify and categorize patterns emerging from the data. Each coder engaged in a nonlinear and iterative process of close reading of data, detailed notation, open coding, and constant comparisons of codes within and across cases. We aimed to identify common codes from manager responses across all prompt questions, as opposed to codes emerging from responses to any single question or select set of questions. We subsequently aggregated codes into primary dimensions based on thematic relationships with respect to the formal organizational roles of persons with lived experience and their impact on treatment facilities.

After independently conducting these coding steps, we pursued inter-coder agreement by comparing the coding themes that emerged from data associated with the first phase of interviews. We engaged in thorough discussions to resolve the limited discrepancies in coding. Data analysis procedures for the second phase of interviews then mirrored those of the first phase and occurred subsequent to the development of preliminary findings. This process ultimately yielded agreement on the primary dimensions that informants identified as pertaining to the organizational roles and impact of personnel with lived experience.

FINDINGS

This study aimed to unpack managerial insights into the organizational roles and impact of personnel with lived experience in behavioral health treatment facilities. Nearly two-thirds of the managers interviewed currently integrate personnel with lived experience into their organizations on a formal basis, albeit at varying degrees. Organizations in our study adopting this service

delivery model tended to have higher numbers of full-time equivalent employees (FTEs) and were primarily non-profit treatment facilities. Importantly, the behavioral healthcare facilities in our study find consensus around goals to advance performance objectives, primarily in treating substance abuse; advancing mental health well-being for historically disadvantaged and vulnerable groups; and helping clients transition back into community living.

In the following subsections, we present findings on the specific organizational roles of persons with lived experience and their perceived impact on treatment facilities. We include the insights of managers whose facilities did and did not integrate personnel with lived experience; including both samples produced more holistic insights than relying exclusively on views offered by managers whose organizations had adopted the service delivery model in question.

Organizational Roles for Persons with Lived Experience

Our informants' facilities integrated persons with lived experience into various organizational units. Personnel with lived experience most frequently occupied internal nonclinical roles (each of which was unique to a given facility), engaged in external outreach, and served on governance bodies such as boards of directors. To a lesser extent, they occupied clinical roles in which they worked alongside licensed physicians. Most of the aforementioned roles ranged from permanent to temporary or intermittent positions. Commitment to formal peer support roles inside *and* outside of clinical confines demonstrates that behavioral health facilities endorse both clinical and nonclinical approaches to recovery. Regardless of the position, personnel with lived experience worked within the parameters of highly specific and clearly defined roles.

Additionally, those with lived experience, almost without exception, were required (legally or by organizational policy) to complete the same accredited training and/or obtain the same licensure

or certification as any of their colleagues. Moreover, the facilities generally had organizational policies that required a specific length of time to have elapsed following completion of treatment before a person with lived experience became eligible to occupy a position within the organization, with the length of time required varying across organizations.

With respect to nonclinical support, managers hired employees with lived experience in roles frequently identified as (or akin to) peer support specialists, recovery coaches, health specialists, or employment specialists. In these roles, former recipients of mental health services used “personal knowledge and experience of a particular issue to help and support others who [were] experiencing that same issue” (Bradstreet 2006, 34). These specialist and coaching roles were “designed to be occupied only by people who have experienced significant mental health problems—this in effect is their qualification” (Bradstreet 2006, 34). For example, an employment coach would formally advise the facility’s current clients on obtaining and maintaining steady employment during and following the completion of clinical treatment.

Even though the nonclinical roles were generally tied to ancillary services, these services were fundamental to clients on the path to recovery. In fact, doctors in one facility advocated for increased roles for workers with lived experience to operate as peer specialists in ancillary service units. According to a nonprofit facility manager:

Doctors have been advocating for a way to make it easier for us to employ individuals who are peers [of clients] . . . We want to hire someone who has been through the child welfare system, who has had his or her children taken away from them, and then gone on through their process of having to work with [the Department of Child Services]. We want people who are recovering from substance abuse conditions to be able to come back and serve as peer workers, and we can see a role for peer workers in crisis services [and] in recovery work. There’s so many possibilities.

This manager went on to remark,

Man, oh man, do we love to have peer workers in our workforce. We are wildly enthusiastic about that concept. We've had several peer specialists. We would hire a dozen today if they were available. There's nothing more powerful than someone who has been through the mental health system, who can come back employed—well on the road to recovery—and inspire others that there is hope, there is recovery. We have had one person here who has told her story so beautifully that she'll go visit someone in a state hospital, and say, 'Yes, I've been here. And yes, I've been in jail; and yes, I've had an addiction; and yes, many, many things have happened in my life. However, I'm here to show you that recovery is not only possible—it's probable. I'm here. I've got a job I love. And you can too.' You can give me a psychologist and a [Licensed Clinical Social Worker]. They all play a very important role, but I don't think any has more impact on a very visceral level than the peer workers.

Personnel with lived experience also held clinical positions in treatment facilities.

Clinical work requires individuals to hold clinical degrees and/or licenses, and clinical roles specifically designed for personnel with lived experience were less common than the previously discussed nonclinical roles. However, governmental Veterans Affairs medical facilities in our study, in particular, had integrated extensive arrays of clinical roles designed specifically for persons with lived experience. According to a nonprofit manager,

It's not uncommon for someone to choose this as a career path. They may go back to nursing school or get their degree to be a counselor and want to come back and work at a place where they feel they got their own recovery.

A third pathway for persons with lived experience was to be hired for external outreach purposes, based on their knowledge of where to locate individuals with behavioral health treatment needs. Compared to the other roles identified by our study, those in outreach-oriented positions engaged almost exclusively with their organization's external environment, and specifically with prospective rather than current clients. A government manager noted,

Our outreach workers are people that [had] been using drugs and substances [who are now] in recovery. [They are] set aside from the normal health department employee because we need to have people where they can meet them where they are on the street, and to communicate with the people on the street in order to provide these services.

A fourth role for individuals with lived experience was a position on a board of directors, or comparable governance body, most frequently in nonprofit organizations. In this capacity, they shaped facility missions, objectives, and strategies; they did not serve in dual roles as board member and staff. One manager of a Federally Qualified Health Center commented that the agency was required to have at least 50 percent of their board of directors be recipients of services. Another government organization created an advisory committee entirely comprised of individuals with lived experience. The manager of the organization housing this committee stated,

We have a consumer advisory board. They don't work *for* us per se, but they work on projects *with* us. They advise us . . . and kind of [have] a say so . . . It's been incredibly helpful for the staff understanding [clinical issues] from a different perspective.

Organizational Implications

Overall, organizational managers perceived positive effects when facilities formally integrated persons with lived experience. First, formally integrating persons with lived experience elevated trust between service recipients and service providers, where peer support workers confer a level of credibility and proof that recovery is possible. According to managers, the trust generated by the workers with lived experience, in effect serving as intermediaries, opened previously unattainable communication channels between the organization and its clients, fostering sustainable client interactions. According to a nonprofit manager,

I remember one [time] where one of our staff had a peer worker go with her to visit someone who was in a state hospital, and it was someone that [our employee] just couldn't engage. So our peer worker goes with her and, all of a sudden, there is this conversation that is just so productive and informative that never before [occurred]. Trust just came immediately. You know, there's just an immediate trust. If they're talking to a psychologist, for example, [clients question] 'How can you know my life, in my world?' But if you're talking with

someone who is a peer, those trust barriers are broken immediately. We've just seen it over and over.

Similarly, another nonprofit manager remarked,

It's huge, to be honest. It's a way to kind of bridge the gap between the patient and provider when you can have someone that can reach out to a person that is currently suffering from substance use disorder [or] mental illness. Having an advocate for them and someone that's gone through it can be really helpful.

Second, formally integrating individuals with lived experience into the organization enhanced the perspectives of the clinicians providing treatment. Even though clinical staff are trained to provide behavioral health treatment, effective intervention often requires a client-centered perspective difficult if not impossible to achieve through clinical education alone. The enhanced perspectives resulting from working alongside employees with lived experience did not serve as a substitute for clinicians' formal education and training, but rather supplemented their academic knowledge. According to a nonprofit manager,

I think it's a really good [recovery] model. The problem is finding enough [personnel with lived experience] who are willing to go through the training. Their ability to communicate with our clients on a peer level is [a] really great advantage in terms of being able to get information across and [gain] a deeper understanding of the client's perspective of what's going on. I think they really contribute a perspective that we miss otherwise.

A manager of a government facility similarly remarked,

Having folks [with lived experience] interacting with the staff has been very helpful in understanding [treatment] from the patient perspective. [They] give us feedback, like 'Hey, you know, this is kind of the experience and maybe you need to tweak some of that' . . . It's been incredibly helpful for the staff understanding things from a different perspective.

Third, while the types of services that facilities offered were not necessarily altered because of the integration of personnel with lived experience, managers commented that including such personnel enhanced the quality of services throughout the organization. Persons

with lived experience often motivated other staff within treatment facilities to take a hard look at organizational and treatment design. According to a nonprofit manager,

Having persons with lived experiences is something that I believe is critically important in terms of really getting to a real understanding of how to make sure your customer service is strong and making sure that your program design and operations are clear and are client-friendly, client-centered. It keeps leadership at all levels very grounded into the day-to-day operations of how to provide good patient-centered care.

Numerous managers commented that outreach services, in particular, were enhanced because of the work of personnel with lived experience. A government manager noted that, as a result of hiring individuals with lived experience,

we provide outreach during nontraditional times. We provide outreach techniques in nontraditional venues. We go out on the street corner, or in a shooting gallery, or wherever the clients are. We try to bring those services to them.

Despite the overall positive experience of managers whose organizations integrated personnel with lived experience, a number of managers led organizations that did not adopt this service delivery model. These managers cited blurred boundaries, inadequate resources, and possible peer worker relapse as reasons their organizations did not integrate personnel with lived experience. Managers with facilities adopting this service delivery model considered these issues among the leading pitfalls of having staff with lived experience, if not managed effectively. In terms of blurred boundaries, managers discussed the fear of “dual relationships” and the difficulties associated with staff interacting with peer workers who were previously clients. Second, appropriately supporting peer workers requires a level of financial and human resource support to which some organizations could not commit. One manager remarked,

The biggest concern is being able to fund [peer worker programs]...Then when you apply the extra cost to supervise it and to carry it out well, it by far is a deficit program.

Finally, multiple managers believed that hiring personnel with lived experience could have adverse effects for these employees and increase the likelihood of relapse from being in an environment that could “take them back to what they were going through.”

DISCUSSION

Our study findings strongly suggest that employing persons with lived experience will result in at least two consequences: (1) passive or symbolic representation of service recipients within behavioral health facilities and (2) active representation, in which the lived experience is a conduit for both increased credibility and trust between service recipients and behavioral health systems as well as a greater understanding of service recipients on the part of the others in the bureaucracy. We are aware that applying lessons learned in a specific professional environment to situations unrelated to that context requires considerable caution; after all, practices found beneficial in behavioral health facilities may not necessarily translate to other human service organizations. Nevertheless, the study findings suggest several ways in which including personnel with lived experience relevant to the population being served can enhance active representation.

The present study’s findings demonstrate that the link between passive and active representation on the basis of lived experience is conditioned on the prevalence of peer-provided services *and* the organizational context and available supports in which lived experience is deployed. Passive representation of lived experience is evidenced by the many organizational roles that peers occupy—including certified peer support specialists, crisis and outreach specialists, governing board members, and, to a lesser extent, behavioral health clinicians. In this way, managers embed employees with lived experience to signal a successful model of recovery

to current and future service recipients. Further, the use of peer-provided services demonstrates an organizational commitment to engaging with and learning from the experiences of former service recipients. Even in its passive form, managers tout the representation of individuals with lived experience as conveying an implicit message about the organization's mission and values, activating a distinct organizational identity.

Moving from passive to active representation, managers leverage their employees' lived experience to augment trust between the organization and its clients. Improved trust represents an important pathway for better client outcomes, particularly when distrust in government (Jones 2016; Pew Research Center 2015; Whetten et al. 2006) and stigma surrounding mental health issues and addiction (Barry et al. 2014; Luoma et al. 2007; Gary 2005) remain high. For socially marginalized populations, particularly in the healthcare domain, that distrust and fear of stigma is often magnified (Whetten et al. 2006; Gary 2005). Agencies whose workforce includes persons whose experiences mirror that of the population being served may be uniquely suited to ameliorate these barriers to successful recovery. Importantly, senior managers also emphasized the ability of persons with lived experience to introduce distinct, relevant knowledge that cannot be replicated through education and training alone. In this way, a staff member who has actually lived with the problems the agency is charged with addressing can serve as an educational resource for employees or governing bodies who lack such reference points. The first-hand perspective that is available from a co-worker can supplement the sorts of formal training that impart skills and abstract knowledge.

In the behavioral healthcare system, we found that the link between passive and active representation on the basis of lived experience is neither inherent nor automatic. Managers of behavioral health facilities emphasized the importance of institutional and contextual factors that

foster or impede the link between passive and active representation, factors also highlighted in existing research (Capers 2018; Keiser et al. 2002; Riccucci & Meyers 2004; Watkins-Hayes 2011; Wilkins & Williams 2008; Wilkins & Williams 2009; Wilkins & Keiser 2004).

Specifically, senior managers identified specific organizational mechanisms to reduce challenges associated with integrating persons with lived experience. This included clearly defined roles and responsibilities, education and training, formal supervision and monitoring processes, and policies/rules that outline clear boundaries between persons with lived experience and clients (see Borry, DeHart-Davis, Kaufmann, Merritt, Tummers 2018). Further, representation through lived experience must be designed to account for the learning curve that clinical and administrative staff will experience when working with colleagues with lived experience; this is necessary to avoid undermining existing clinical and administrative strengths and to provide frequent reassurance that professionals and nontraditional professionals can co-exist organizationally.

A number of caveats and limitations to this study merit discussion. First, our findings, while providing a basis for subsequent theory development, are not facts, but a compilation of managers' interpretations—shaped and explained by their roles in distinctive policy contexts. As a result, these findings cannot be interpreted as objective data (Maynard-Moody & Musheno 2003, 23). Second, the managers interviewed provide a high-level (and potentially abstract) perspective, because they are not direct service providers. A potentially richer analysis, and one which is less vulnerable to desirability bias, might result from interviews with service users and providers at treatment facilities (both with and without personnel with lived experience) to flesh out any distinctions in service provision and subsequent implications for organizations. Third, the organizational policies that govern the integration of persons with lived experience (e.g., job

position eligibility) in ways that maximize active representation of clients warrants further scholarly attention. Statistical modeling may also identify the extent to which lived experience of managers or service providers and organizational context collectively lead to active representation for program participants.

CONCLUSIONS

Public administration and human service organizations research have confirmed the value of a broadly representative bureaucracy. To date, however, the attributes that are thought to constitute representation have been largely confined to immutable demographic identities or characteristics. By and large, the behavioral health treatment facilities in our study have expanded their definition of representation to include people with lived experience relevant to the population being served, and their overall positive experience suggests that this approach merits consideration by other public-serving agencies and organizations. If the definition of representation is expanded to include such individuals—and if care is taken to develop roles and job descriptions that make thoughtful and appropriate use of their experience—more organizations may see improvements in their capacity to serve their clientele.

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Table 1**Respondent Characteristics**

Characteristics	% of Sample (N=26)
<i>Gender</i>	
Female	53.8
Male	46.2
<i>Years of Experience in Current Management Position</i>	
<6	38.4
6–10	30.8
11–15	15.4
>15	15.4
<i>Organization's Legal Ownership</i>	
Government	30.8
Nonprofit	42.3
Private for-profit	26.9
<i>Organization's FTE</i>	
<100	57.8
100–500	23.1
501–1,000	11.5
1,001–1,500	3.8
>1,500	3.8
<i>Presence of Organization-Designed Roles for Persons with Lived Experience</i>	
Yes	65.4
No	34.6
<i>Organization's Service Type</i>	
Outpatient treatment center	57.7
Residential treatment center for adults	34.6
Residential treatment center for children	7.7

Appendix

Semi-Structured Interview Protocol

1. Identify and discuss performance outcomes of your treatment facility that the broader public considers important (i.e., public outcomes).
2. Identify organizational and environmental mechanisms that facilitated or constrained your facility's ability to achieve these identified public outcomes.
3. Envision a scenario in which your organization was underperforming in advancing the public outcomes it aimed to achieve. In doing so, identify the internal and external mechanisms that would generate improvement for each outcome.
4. Has your facility ever formally utilized (e.g., hired, appointed) former clients or other persons with lived experience to design, implement, and/or evaluate organizational services?
 - a. Explain the specific organizational roles and responsibilities of personnel with lived experience [if applicable].
 - b. Discuss the degree and nature of the impact that personnel with lived experience have had on (1) organizational performance in general, (2) current clients, and (3) professional staff who do not have lived experience [if applicable].
 - c. Explain the reasoning behind why your organization decided to employ personnel with lived experience [if applicable].
 - d. Explain the reasoning behind why your organization decided *not* to employ personnel with lived experience. [if applicable].