

The experience of certified peer specialists in mental health

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ABSTRACT

Certified peer specialists (CPS) are mental health consumers in recovery from their illness who received special training enabling them to work as paid mental health staff to support other consumers not as advanced in their recovery. This research sought to understand the barriers and facilitators of effective CPS work using a qualitative approach. The CPS that were interviewed reported that the major barriers to effective work are agencies that are not sufficiently recovery oriented, and professional providers who do not understand the CPS role. CPS reported that facilitators included a sense that the work was rewarding, and that the organizations and supervisors were supportive.

KEYWORDS

CPS; mental health recovery; stigma of mental illness

The mental health recovery movement is a social movement of psychiatric consumers who have been working to change the nature of mental health services to be consumer focused. This movement is rooted in the mental health patients' liberation movement that developed in the 1960s and 1970s (Ostrow & Adams, 2012). This movement fought perceived oppression from the psychiatric establishment; eventually, the "patient" voice came to be an influential consumer rights movement that has affected United States mental health policy (Ostrow & Adams, 2012). This consumer voice received a powerful impetus from the President's New Freedom Commission of 2003. This commission was charged by the G. W. Bush administration with recommending improvements in mental health services for those living with mental illness (Hogan, 2003). As the Commission considered how to improve the system, the theme of recovery arose frequently as a result of consumer influence (Hogan, 2003). Consequently, the Commission's final report strongly emphasized the need for care that was consumer driven and rooted in the faith that recovery from mental illness was possible (Hogan, 2003).

Recovery from mental illness has been defined as learning to live well in spite of the existence of mental health impairment (Anthony, 1993). Consumer

driven care, emphasizing recovery is often called The Recovery Model. This approach provides an alternative to the prevalent medical model of mental health care which emphasizes expert treatment of a compliant and non-objecting patient. The Recovery Model, in contrast underscores the need for consumers to be empowered and to partner with their mental health providers. Jenneth Carpenter (2002) makes the case that Mental Health Recovery with its social justice emphases on decrease of stigma and consumer empowerment is consistent with the values of the social work profession. She notes that the medical model of mental health can be at odds with the profession's valuation of strengths, partnership, and empowerment.

A new addition to Recovery Model care is the provision of certified peer specialists (CPS). CPS workers are mental health consumers who have advanced in their recovery and who have received training to enable them to provide support and guidance to others living with mental illness. The underpinning philosophy of the provision of CPS services is the belief that those who live with mental illness and who have worked to achieve their own recovery are uniquely qualified to help others in similar circumstances (Kemp & Henderson, 2012). In this article, the term CPS will be used as both singular and plural.

Davidson, Chinman, Sells, and Rowe (2006) note that the idea that those who have recovered could offer "hope, support, encouragement, and even mentoring" to others living with mental illness, took root in the field of mental health in the early 1990s. These authors explain that CPS services can be distinguished from professional help and self-help by placing the service on a continuum with self-help (e.g., Schizophrenics Anonymous or Recovery Inc.) and consumer run drop in centers on one end and professionally brokered services on the other. This location on the continuum creates a dynamic of tension between the CPS role and the professional role.

Unlike mutual support and consumer-run programs, peer support is thus defined as involving an asymmetrical- if not one-directional-relationship, with at least one designated service/support provider and one designated service/support recipient. This shift from reciprocity (as in mutual aid) to receiver of care has been the source of considerable tension and debate within the consumer community, as peer staff have been viewed with varying degrees of suspicion concerning their having potentially been co-opted by the mental health system. (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006, p. 444, par. 7).

The development and implementation of CPS services have increased since the Centers for Medicare and Medicaid Services (CMS) declared the method to be an "evidence-based model" of treatment in a 2007 letter to state medical directors. The letter notes that, "Peer support services are an evidence-based mental health model of care which consists of a qualified peer support provider who assists individuals with their recovery from mental illness

and substance use disorders” (CMS, 2007, p. 1 par. 2). CMS provided a mechanism for the reimbursement of certified peer support services in 2007 (Eiken & Campbell, 2008).

As CPS are increasingly being implemented in mental health, a body of literature on their work experience has begun to develop. A study of Pennsylvania’s Certified Peer Specialist Initiative located 57 certified individuals 1 year post training to provide information on their employment status, job satisfaction, and experience with supervision (Salzer, Katz, Kidwell, Federici, & Ward-Colasante, 2009). These workers reported they were satisfied with their work. Grant, Reinhart, Wituk, and Meissen (2012) examined the experiences of 59 CPS workers in Kansas. The participants completed a questionnaire called the Job Satisfaction Survey, a measure called the Survey of Perceived Organizational Support, and a Workplace Integration Scale. Results showed that respondents appeared to feel integrated into and supported by their employing organizations. However, research that does not use pre-determined categories to assess the CPS work experience is scarce. One exception is the work Kemp and Henderson (2012). These researchers used a qualitative method to interview seven CPS using an approach called “The Nominal Group Technique” (NGT). Participants noted that many of those they interacted with in conducting their work had a poor understanding of their role, which caused them to feel excluded.

Mead, Hilton, and Curtis (2001) wrote about CPS from the perspective of consumers functioning in this role and as leaders in the Mental Health Recovery Movement. They noted that the purpose of CPS, in addition to providing mentoring in recovery for peers, is to raise consumer consciousness about the dominant social discourse of mental health. This discourse defines consumers as “patients,” which is a label that is seen as removing their individuality and power. This consciousness raising and service provision has potential to upset the power balance of the mental health profession. In a Boston Globe article by Carey Golding (2007), Yale researcher Larry Davidson notes that not only do people with mental illness feel unaccepted by professionals, in turn, professionals resist CPS. “Though the new field is growing, resistance remains, Davidson and others said. They worry that staff and clinicians without mental illness could feel threatened by the influx of newcomers whose experience with illness is considered an asset”(Golding, 2007, p. 2).

The concern that providers may resist CPS is not unwarranted. Chinman, Young, Hassell, and Davidson (2006) conducted a study at three Veterans Administration (VA) centers in Southern California to discover how administrators, providers, and patients perceived the viability and suitability of offering CPS services. A difference was found in attitudes toward CPS between providers and patients. While all groups were enthusiastic about the potential for CPS, professional providers raised concerns about their need to remain in control of supervising CPS, fears that CPS

work would exacerbate symptoms and fears that professionals would be liable if CPS work had adverse outcomes. In a similar vein, a literature review combined with results of a roundtable discussion with consumer providers and supervisors on barriers to hiring consumer providers in mental health found that concerns to hiring consumers existed (Carlson, Rapp, & McDiarmid, 2001). The most prevalent concerns reported were: fears of dual relationships between consumer providers and those they serve, role conflict and confusion, and reservations about the maintenance of confidentiality.

In order to ameliorate potential resistance to the hiring of peer specialists in mental health, a Texas group called Via Hope trained peer specialists and then worked toward creating job sites by developing peer specialist learning communities (Frost, Heinz & Bach, 2011). It was anticipated that guidance and support in implementing peer specialists worksites would be provided. Data collected from mental health providers showed that the recovery orientation of participating organizations only changed modestly as a result of the employment of peer specialists. Frost et al. (2011) concluded that more must be done to assure that the culture of mental health organizations changed to support recovery oriented practice.

In spite of concerns over the hiring of consumer providers, along with the need for mental health agency cultures to become more recovery oriented to better support peer specialists, there are personal and social benefits that accrue to these workers. Johnson et al. (2014) sent an anonymous Internet survey to mental health peer support specialists. The survey inquired about personal, social, and professional benefits of the work. Two hundred and fifty-three peer support specialists responded. Respondents reported that benefits of their work included: greater confidence, improved perceptions of their own recovery and for some, termination of dependency on disability benefits.

It is clear that as the employment of CPS in mental health continues to grow these workers can be a source of concern for professional providers. It has been documented that mental health professionals are resistant to the Recovery Model (Davidson et al., 2006b) and that mental health professionals may not welcome consumers as colleagues (Gordon, 2005; McCann, Clark, Baird, & Lu, 2008; Soffe et al., 2004). Therefore, it is important to assess if CPS workers perceive professional resistance to them. This can be explored through an inquiry into CPS perceptions of barriers to and facilitators of their work. An inquiry into the CPS perspective is consistent with social work's professional concern with social justice and empowerment.

Goals and objectives

The goal of this research was to explore the CPS experience from the perspective of the workers. This work sought to describe the experiences of the

workers, and what they perceived to be the barriers and facilitators of effective CPS practice. This goal was accomplished through the use of a qualitative methodology.

Method

Since little research was found regarding CPS workers' subjective experience of their work, a qualitative methodology was chosen. Qualitative research allows in-depth understanding of phenomena of interest and is a theory-generating activity (Rubin & Babbie, 2008). This work also relied on an action research focus (Brydon-Miller, 2003; Brydon-Miller, Greenwood, & Maguire, 2003), which engages academic researchers in collaboration with stakeholders. Stakeholders are defined as individuals who are personally affected by the knowledge that is sought. One of the principles of this collaborative approach is empowerment; therefore, a stakeholder collaborator should be compensated to assure true partnership with the academic researcher. The stakeholder should be an integral part of the work and never feel exploited by it. The stakeholder's interest and voice must be respected. Therefore, this research engaged a CPS as a compensated collaborator. The CPS (second author) filled the role of co-principal investigator and was paid for his services. He contributed to all aspects of the project including: designing the interview guide, participating in data collection and analysis and finally, assisting as a co-author.

This research was approved by the Internal Review Board of East Stroudsburg University.

Sample

All research respondents met the criteria of being trained and/or employed as CPS workers. Sample size was concerned with generating enough data to allow in-depth understanding to emerge. The research team, comprised of all the authors of this article, agreed to seek as many CPS as possible in our geographic region including both rural and urban areas. Our sampling method was both purposive and criterion based (Padgett, 1998). We knew the sample was sufficient once nothing new emerged from the data. Our focus was on quality of the sample rather than quantity, an important consideration in qualitative work (Padgett, 1998).

A list of agencies from three rural counties that hired CPS was generated from the local office of mental health. These counties comprise the geographic region in which we are located. Agencies were approached through e-mail and phone call by the first author who explained the work and obtained permission to approach the agency's CPS. Importantly, all contacted agencies currently

employing CPS responded and gave contact information so CPS could be approached and invited either to attend a focus group, or an individual interview at the workers' convenience. Some agencies that were approached because of their reputation for hiring CPS informed us they no longer had any on staff.

Once the initial group of CPS was interviewed they were asked if they knew other CPS who might like to speak to us so that we could try to enlarge the sample. Those interviewed either individually or in a focus group were asked if they knew any other CPS. This method did not yield more respondents since participating CPS already knew the other local CPS that we were contacting. Two CPS respondents recommended contacting agencies in other counties where they had worked in the past to help us enlarge the sample. However, those agencies did not enlarge the sample. One agency respondent replied that she no longer oversaw CPS and referred us to someone else who did not respond. The second respondent sent a polite e-mail noting he was too busy to approach his CPS staff regarding whether they would permit being contacted.

In addition to the steps described above, one of the researchers who is a CPS approached a small group of colleagues who consented to participate in a focus group. A total of three focus groups were conducted, and three respondents were interviewed individually. In one focus group, one potential respondent walked out and declined to participate.

Focus groups and individual interviews were conducted at the CPS workplaces. One focus group was conducted at a consumer run agency and two others were held at consumer run programs located within traditional mental health settings. A total of ten respondents were interviewed in focus groups. The largest group consisted of six respondents and the other two consisted of two respondents.

The final sample size of 13 consisted of seven males and six females. Respondents worked in eight different mental health organizations. Five respondents worked in an urban area, and the rest were employed in rural areas. All the respondents were employed part time as CPS and all were on disability. In research like this, where the data consist of respondent words, there is always the potential for identification. Therefore, to protect respondents as much as possible demographic data such as age, years in recovery, years employed as a CPS, education and race were not collected.

When the data obtained in a qualitative study yield all that can be learned about a phenomena of interest, this is termed data saturation (Padgett, 1998). In qualitative exploration, once nothing new is learned the researcher can make a judgment that new cases no longer need to be sought. The research team found similar material emerging with each interview and by the time we reached our thirteenth interview, we felt nothing new was being discovered and that the point of saturation had been obtained.

Data analysis

The use of grounded theory guided data interpretation. The focus of the grounded theory approach is to develop theory without being biased towards “specific kinds of data, lines of research, or theoretical technique” (Strauss, 1987, p. 5). A theory emerges from the data through the process of careful perusal of the material for themes and categories.

The interview data yielded 57 pages of single spaced interview material. A method of coding described by Miles and Huberman (1994) was utilized. This approach entails using coding to categorize excerpts from the interviews according to units that related to the study focus and then reviewing that assignment further to assess whether the data could be differentiated and categorized more precisely. This process of constant review and revision was continued until it appeared that all possible meaning of the data was explored. The process was aided by use of the qualitative analysis software NVIVO 10 (QSR International).

The first author began by coding the data initially according to the themes explored in the flexible interview guide, which is reproduced in [Table 1](#). These themes included: job description, CPS training, experience with discrimination or stigma, experience collaborating with providers, barriers and facilitators, and organizational integration. As data were excerpted into these initial categories, subcategories became apparent. Initially barriers encompassed 10 subcategories; experience collaborating with other providers incorporated four subcategories; facilitators included nine; and job description included two. This coding was reviewed repeatedly in order to interrogate the organizational scheme and modify as needed. As this process continued, reliability was ensured through ongoing review by the research team to discuss the categorizing as it emerged so we could continue to refine until everyone on the team agreed with the final interpretation. The final coding included: job description, barriers to effective CPS work,

Table 1. Flexible interview guide.

Please tell us what your job is like. (Do you have a clear job description? Are your daily duties consistent with your job description? If yes, how? If no, how? If respondents indicate anything is lacking, follow up; prompt as needed)
Does the job you do reflect your CPS Recovery Model training? (If yes, how? If no, how? What is left out of your job that your training prepared you for? Did your training prepare you for the things you find you routinely deal with?)
Talk about your experiences collaborating with providers, medical professionals, and other agencies?
Do you find any barriers that keep you from being effective as a CPS? If so, please share. Also follow up with a question about what helps facilitate one's most effective work.
Do you feel you are well integrated into the organization that employs you?
It is well documented that there is stigma endured by those coping with mental illness. In fact, the Mental Health Recovery Movement seeks to alleviate this and use of CPS is one way of trying to do that. Is there any stigma endured by CPS workers? If so, please describe it.
Is there anything we haven't asked you about the work that you'd like to share with us?

facilitators of effective work, CPS training, discrimination, and organizational integration. Table 2 displays the final coding scheme and lists how many subjects and excerpts reported data that fit into the code. At times, one excerpt contains comments from more than one subject.

Reliability and validity

The members of the research team reviewed the categorized material seeking to refine the organizational scheme as it emerged. The team sought to eliminate areas of overlap and develop greater levels of precision in deducing a descriptive framework for the material. The team discussions and reviews provided a check on bias, which is a serious risk in qualitative research. Padgett (1998) refers to ascertaining the trustworthiness of findings in qualitative research. Others refer to this concern in terms of issues of validity (Miles & Huberman, 1994). One way to deal with threats to the validity and reliability of data interpretation is to ensure checks on the interpretive scheme. In our case this was done through having all members of the team review the scheme that emerged and discuss various points of view during team meetings. These efforts were our attempt to minimize interpretive bias as much as possible.

Finally, we sent a draft of our interpretation to as many of the participating CPS as possible to ascertain whether they felt that our understanding of the

Table 2. Categorization of interview data.

Category	# of respondents	# of excerpts
Job description	12	12
Barriers		
Boundaries	2	2
Job stressors	3	3
High caseload	1	1
Consumers not ready for recovery	2	2
Medical model	12	21
Providers not taking CPS seriously	9	17
Being assigned work that is not perceived as consistent with training and legitimate duties	2	2
Discrimination	3	2
CPS training was a positive experience	13	13
Facilitators		
Supportive organization/CPS supervisor	8	8
Funding	1	1
Region	1	1
Reputation	1	1
Helping alliance	1	1
Work is rewarding	2	2
Patience	1	1
Good support	2	2
Organizational integration		
Integrated	9	7
Not integrated		4

data genuinely captured their experience. One year after the interviews were complete we sought contact information for respondents from the agencies that gave us access to interview the CPS staff that we sampled. Some agencies did not respond. We were able to locate eight of the 13 respondents. We reached out to them to request they read the draft. Three did not respond, but five did review the draft and reported satisfaction with it. These respondents felt our interpretation reflected their experience as CPS.

Results

CPS job description

Twelve respondents described their CPS job responsibilities. One respondent was trained as a CPS but was not employed in that capacity; therefore no current work description was supplied. This individual worked as a peer mentor rather than as a CPS.

The 12 excerpts described their work as having the focus of peer support, but certain tasks were specific to each CPS employing organization. For example, two worked for assertive community treatment teams (ACT). In addition to peer mentoring, these workers coordinate between peers, providers and payers, handle client emergencies, and liaison between peers and ACT treatment staff. Some CPS respond to peers in their home, some only in the office. Some worked primarily one on one, while others also facilitated recovery focused groups. All of the respondents spoke of trying to empower peers, establish recovery goals and implement them, and function as an advocate and a role model. All CPS were clear that the helping process was not one of mutual aid, but rather one in which they were the service provider as described by Davidson et al. (2006a).

Barriers to effective CPS work

Boundaries

When asked about barriers to effective CPS work, two respondents spoke about the difficulty involved in maintaining appropriate boundaries between themselves and their client peer. The very title “peer support” can easily engender confusion about boundaries. Some consumers may wonder: if the CPS is a peer then does that not also mean they can be a personal friend?

Respondent 13: Boundaries were really not set in place. They are your peer, and you are a professional. You know, there is a fine line there. Honestly, I had to deal with the relationships that were messed up before I arrived due to a lack of clear boundaries. So, I had to get people to trust me again, to trust a peer specialist again.

Respondent 11: Barriers—yeah, well the problem is that I know a lot of people, and one in particular, she used to be my friend and now she is my client. So, it's

difficult. In the beginning she used to call me—and we weren't friends anymore—and she'd say can you tell my case manager this or that. I had to tell her that was her responsibility, not mine. So, it's like you have to have boundaries and you have to know how you can act with certain people. You can't act too friendly to one and not the other. You have to treat everyone equally.

Job stressors, high caseload, and consumers who are not ready for recovery

One respondent described a caseload that was too high as being a barrier. Two discussed the experience of working with acutely ill consumers who were not yet ready to engage in recovery. Three described job stressors as barriers. The comments about job stressors follow.

Respondent 2: (describes working in a lockdown unit with very acute clients). I didn't sleep all week. Wednesday night I'm thinking, "What am I going to do?" I told my supervisor I needed a break. He said, "When?" I said, "Now." I left at noon and was out for probably 7 days. The job compromises my own recovery. It is a lockdown with individuals who are engaging in behaviors that are threatening, assaultive to themselves, to other people. You're working in a really high risk situation.

Respondent 12: The only problem I see is that some days I feel like I'm carrying their load and my load. The peer's load and mine. And that sometimes gets to me. So my employer allows me to work only 2 days per week. So, that gives me time off in between to get myself centered again.

One respondent described working in a group home environment where there was a lot of structure and supervision. She reported feeling this kind of setting tended to encourage dependency, which prevented consumers from feeling empowered to take responsibility for their lives and recovery. The constant noise and bustle of the residence made it difficult for her to get consumers to focus.

The medical model as a barrier

The most significant barrier that was reported by 12 subjects, and noted in 21 excerpts had to do with a barrier we labeled "medical model." This barrier describes the workers' perceptions that their employing agencies and/or colleagues were not "recovery oriented." The workers seem to be describing their subjective sense of how an agency "should be" compared with their actual experience of it.

Respondent 5: My name is _____. I work at _____. My job there is as a CPS. I currently am finding that it's not recovery oriented—the treatment. It's more clinical. Which, therefore, it DOES need to be clinical as well, with medications being dispersed and psychiatrists and therapists, but also they do not incorporate recovery into their role. And I feel there needs to be a lot more recovery oriented interactions with our clients than just clinical.

Respondent 3: I don't think the job that I'm doing reflects recovery model training. As a supervisor my concern is that I need to have stated goals and demonstrate progress in a way that looks very medical model. It doesn't look like recovery to me.

Respondent 6: I find that despite all the focus on trainings and the recovery model that there are fewer and fewer systems that actually utilize it in day to day work—especially in our area with the closure of ___State Hospital. The system is designed to accommodate for its closure but it in no way embraces recovery despite what people would tell you. It's more of a clinical model. I see more of a medical model than a recovery model. I'm horrified by it.

This barrier appears to present a complex and somewhat nuanced barrier to effective CPS work. First, it is important to note how the medical model itself functions to constrain perceptions. Ostrow and Adams (2012) note how the diagnosis of mental illness creates a label that conveys hopelessness and perpetual infirmity. The medical model of treatment, which has prevailed in the mental health field, emphasizes disease and the need for expert assessment and treatment. "Patients" in such a system find themselves labeled with a condition purported to affect their insight and judgment and their future potentials. Because they are seen as lacking appropriate insight and judgment, they may find that professionals do not always include them in treatment decisions, or work to empower and encourage them.

Respondent 3: One of the biggest concerns I have with the medical professionals I work with is what I feel is an incredibly strong tendency for them to dismiss the physical challenges of those with mental health challenges. I believe I have seen people die because of that. I was working with one individual who was sent to the hospital and never examined physically. He had a heart that was failing and he died the day he came back from the hospital. He was never checked. I think if he had not had a mental health diagnosis, the symptoms he was describing would have warranted testing but because of his mental health diagnosis, it was just dismissed.

These CPS often found they were working in systems that did not understand recovery or CPS; some felt they were not treated as an equal.

Respondent 5: At the company, I think they appreciated what I do. But when I would go to different trainings, I would be treated as an equal until they found out I was a peer specialist.

Respondent 10: I don't endure stigma in the office in which I work but I endure it in the mental health field in general. I believe we are looked upon as simply people with mental illness, not people who have recovered or are in recovery. There is no understanding we are fully functioning and capable, intelligent people. I have been referred to as a peer rather than a certified peer specialist. I am certified; I do have training. I am in a professional field. When you refer to me as a peer that diminishes my training and my experience and it diminishes me and all that I have achieved.

Providers not taking CPS seriously

The second largest barrier perceived by CPS in our sample was the sense that providers often did not take them seriously.

Respondent 6: The barrier that I find that is the hardest to overcome is just overall lack of understanding of what a certified peer does. There is no openness to the knowledge. If you want to call it stigma or just plain ignorance—I like to call it ignorance because they're just not aware of what a peer does, or their effectiveness in the mental health field.

Respondent 5: I find that the lack of knowledge and understanding of what a peer support does is definitely a barrier. I don't feel that what I have to say is heard. Because I don't have a degree that makes a big difference I guess in their eyes, when in fact I may have a better understanding of and relationship with the client than they do.

Mental health professionals have resisted the recovery model out of fear that “patients” with “mental illness” cannot recover without their expertise, and that if allowed voice to make their own choices professionals will be liable if “patients” fail (Clossey, Mehnert & Silva, 2011; Davidson et al., 2006b). In addition to fears of ceding control and power to consumers, providers may have no other language for what is called “mental illness” than the language of the medical model itself (Boyle, 2006; Casstevens, 2010). Words are part of the discourse we create to understand something; these words become reified as if they themselves represent objective reality (Casstevens, 2010). Boyle (2006) points out that unless medical words themselves can be replaced with viable alternatives this discourse will prevail. All of this affects consumers who try to fill roles that are between “expert” provider and “patient.” There is no place in the medical model discourse for CPS and the result is poor understanding of how to interact with these workers. CPS workers are often ignored and report having to prove themselves.

Respondent 10: I have been dismissed on a couple of occasion. As though what I had to say had no bearing or significance or that my input was irrelevant. Just cut off—short and curt answers by psychiatrists. A cold shoulder. A lot of mental health professionals are still getting used to CPS being in service. We have been in service for how many years now? And we are still not looked upon with the respect that really should be given.

Respondent 13: You have to prove yourself. Some people aren't always accepting at first so you have to prove yourself. Sometimes the agencies use the peer specialist as their public relations person. There is an ACT team in-town that uses their peer that way. Their peer does all the organizing and answering the phone and some things like that, but he's not used as a CPS.

Respondent 7: I guess the biggest barrier is being heard and being taken seriously. You have to make them take you seriously. I had to develop a style that communicated I wasn't going to allow failing to take me seriously to be an option. You are going to hear me.

Respondent 8: Sometimes I go see the psychiatrist and she says, “oh, how’s it going?” And I say, “well, work’s okay.” But they treat me like I’m a little kid and I’m playing with little tinker toys in the sandbox and that’s their idea. Honestly. That’s my problem. The system diminishes us. It’s getting slowly better over the years but it still is what it is. I’m an idiot the minute I walk into that doctor’s office. I’m a moron.

Sometimes other professionals working in the mental health field evidence concern that the CPS is fragile due to mental illness.

Respondent 7: There is a lack of respect you experience when you have a mental illness. It comes from stigma. I’m very open about my diagnosis and experience with providers. So, if you’re having a bad day then it’s like you’re treated as if you’re broken. So if I have a cold and take the day off everyone is like are you okay? I have an off day and I have a mental illness and it doesn’t mean I’m broken. I’ve seen people treat consumers with baby gloves like they’re scared and they don’t want to “set them off” or say something to trigger them or, you know what not. I’m a certified peer specialist so it’s no secret that I live with mental illness. If a coworker doesn’t know what that’s like and hasn’t had lots of experience with a peer then there’s stigma. They treat you like you’re kind of broken or they don’t take you seriously.

Another aspect of feeling misunderstood by providers has to do with the CPS emphasis on partnership with providers. CPS feel that it is essential to recovery to educate peers about wellness and encourage discussion of medications. However, since the expert enjoys hegemony in the field, the professional decides what can be discussed and by whom. The CPS may feel medications can be discussed as integral to partnership and empowerment, but providers may not agree. The third excerpt reproduced below reproduces comments exchanged between respondents participating in a focus group together.

Respondent 2: I was told not to discuss any medication with the consumer. Only the doctors and nurses can do that.

(Focus group excerpt) Respondent 9: My experience tells me to take my medicines. I use cognitive therapy as well. I feel a lot better staying on my medicines. Respondent 8: to each his own. I have no problem with that. But, I don’t think you should be sentenced to a life of medicines if you don’t need it. Researcher: Are you saying that in your experience the system kind of pushes that? Respondent 8: Oh yeah, absolutely. It seems to be many times all they are interested in is: are you taking your meds? Respondent 1: Just one thing, when we had our WRAP trainings, it said that medications can be a powerful tool, but, it’s in OUR power to take those medications if we want to and to discuss whether or not we want to take medications with our psychiatrists. And that is how we differ from forced medications. Many systems say, you can’t come in here unless you are under the care of psychiatrists and take medications every day. So, I completely understand where you are both coming from.

As advocates, CPS may perceive that peers do not have serious medical issues attended to due to stigma and feel that the professionals will not listen to their attempts to support and fight for those they serve.

Respondent 6: I was working with someone who had a number of hospitalizations which coincided in time with a new medication. I went to the internet and got the side effects of those medications and presented that information to the psychiatrist. Now, I'm not a medical professional, but these documents are coming from medical professionals from online sources. I wasn't interpreting anything to him, I was simply offering him what the manufacturers themselves say happens and that these medications should not be used together. They cause the effects we're seeing in this man who has become very sick. The psychiatrist had no interest in looking at the documents; I think because I have no degree.

Being assigned work that is not perceived as legitimate to the CPS role

Two respondents noted that they had the experience of being assigned work they felt was not legitimate. Poor understanding results in misuse of workers as glorified taxi drivers and clerks. While concern with transportation for peers is important, these workers were trained NOT to assume the liability of transporting their peers, but rather assisting them in accessing transportation services. In addition these respondents reported perceiving that their work is trivialized.

Respondent 10: Well, one particular thing comes to mind—they tend to think we're a taxi service. And we are to drive peers to appointments and we're to drive them to the supermarket and this is not the case.

Respondent 1: I have a peer who was told by the county officials that a certified peer support would drive him to appointments and take him shopping!

On the other hand the worker may perceive being used to do more than he/she should for less than he/she is compensated. Respondent 3: "I worked for the state. The job description was for CPS but I was told, 'you don't have time to do anything on that job description. You have other duties that we will assign.' My job duties looked like the work of someone at a lower pay grade doing higher level work."

Discrimination

Russinova, Griffin, Bloch, Wewiorski, and Rosoklija (2011) analyzed data from a national sample of people living with mental illness. Two hundred and two participants answered open ended questions assessing whether they noticed negative attitudes about mental illness in their current work environment. They were also asked to describe the worst stigmatizing event they ever experienced at work due to their psychiatric condition. The authors used the responses to develop a classification schema of manifestations of workplace prejudice. These authors found that one manifestation of discrimination was that workers were treated with condescension and patronization (Russinova et al., 2011). As illustrated by some of the material cited above, some workers in our sample did feel demeaned by providers. This can probably be corrected through mental health organization culture change and better provider education about CPS.

The experience of discrimination from the surrounding community and encounters with colleagues who hold stereotypical beliefs about people living with mental illness are reported by some of our respondents. This type of discrimination was discussed in two excerpts by three respondents. The second excerpt represents an exchange between two respondents during a focus group.

Respondent 6: I have seen stigma on countless occasions in my 10 years in this field. Two weeks ago I had to literally go out of my way to convince one of our newer hires that I have my own mental illness. She questioned how someone with a mental illness could take care of a young child. And I pointed out that my 4 year old is doing quite well. She still doesn't believe me. I have had people simply just tune me out and disregard what I had to say like I'm not even speaking. I'm not exactly the quietest person in the room.

(Focus group excerpt) Respondent 8: Well, around here we have experienced stigma from our neighbors. They know what we're here for. (The neighbors are aware that the agency offers mental health services) Respondent 9: The people up on ____ street; they know about our gang. They wanted to have their smoke breaks, they see the gang, and they know all of our faces. We're part of the gang. Respondent 8: And every now and then they'll be yelling at us from their cars. Not a lot, but it does happen. We have one guy down here by the ____ (names a local restaurant), he is just out and out rude to our people. Nobody will go there anymore. Respondent 9: We boycotted them.

CPS training

All respondents were asked whether their CPS training prepared them for their work and whether they had any suggestions to improve their training. All respondents indicated positive feelings about their training. One subject stressed the need for more information about trauma in the training since many peers suffer from a history of significant abuse. Another respondent who has a professional degree in psychology felt the CPS training was a reiteration of what she had learned in college coupled with a lot of what she felt was "common sense."

Facilitators

Supportive organizations and having a CPS supervisor

Respondents were asked what facilitated their best work as CPS. Eight subjects reported that a supportive organization and/or a supervisor who was a CPS optimally facilitated their best work.

Respondent 1: I'm particularly helped by my supervisors because they were all CPS before they became CPS supervisors. I have, in the past, worked where people had no idea what CPS support was all about.

Respondent 2: He's really a great supervisor. (Supervisor is a CPS). I mean, I love the guy.

Respondent 3: I am very happy to be supervised by someone who is themselves a CPS. I have had other positions where that was not the case.

Respondent 1: Also regarding what helps me facilitate my most effective work is that the company I work for right now is consumer run. Every supervisor is a certified peer specialist.

Respondent 6: What would help me facilitate my most effective work would be to have the organization understand, appreciate and acknowledge the importance and effectiveness of what a peer does, and to not treat them as underpaid case managers or a taxi cab service.

Respondent 14: The organization matters when it comes to doing the best work. One organization I worked for, the entire place was very recovery focused. It really depends on the agency and it depends on how much the agency listens to the people that are on the front line.

Funding, geographic region, reputation, helping alliance, rewarding work, patience, and a good support system

One respondent said that adequate funding facilitated the best possible CPS work. Another said that the geographic area actually mattered. This respondent was presently working in a rural area but, in the past had worked as a CPS for an agency in an urban area. She felt that she encountered more progressive attitudes towards the mentally ill in the urban environment. One CPS respondent said he had a good reputation, which gave him an advantage. Since he was well known and respected his work was facilitated. Five CPS noted that good training facilitated their most effective work. Two said that the helping alliance was the single most important facilitator along with the rewarding nature of the work. One worker noted that her patience facilitated her best work. Finally two stated that a good support system was crucial to effective work.

Organizational integration

At the end of the interviews all respondents were asked whether they felt they were well integrated into the organization that employed them. Three worked specifically for a consumer run organization. Three others worked for a psychiatric rehabilitation program staffed extensively by peers, but the organization offering the program was not consumer run. All of these workers reported that they felt integrated.

The remaining seven worked in traditional mental health settings. Three respondents discussed feeling disconnected from their employing organization. One noted that she felt integrated into her particular program but not into all aspects of the organization. Three respondents felt their agency integrated them and overall they felt supported.

Respondent 6: No, I do not feel that I am well integrated. I do not feel the organization appreciates the role of a certified peer. I don't feel the proper amount of importance is placed upon the work that the peers do and we're limited in our abilities to utilize the skills we have. I personally feel that I have been held back from promotion within the organization due to my diagnosis.

Respondent 5: (comes from same agency as respondent 6) I do not feel that I am well integrated; I feel that I am not appreciated. I feel that I am not heard because of my role and because I do not have a degree.

Respondent 13: I'm not as integrated here. And I feel that they're more judgmental.

Respondent 11: I really like the people I work with. We do things socially and we talk and we all get along and they all respect me and I'm really glad that I'm in this organization.

Respondent 12: I was treated here and they suggested I become a CPS. They actually assisted me in paying for the training and then hiring me. So, I really feel they believe in me.

Conclusions

The findings of this qualitative work are similar to the results reported by Kemp and Henderson (2012) who conducted interviews of seven CPS workers in Australia. These authors noted that the main problem of these workers is experiencing marginalization due to lack of comprehension of their work. We found this result too. We speculate that some of this may be attributable to a mental health agency culture that is not fully recovery oriented.

The barriers that were noted the most among respondents in our study include: medical model culture, trouble collaborating with professionals, struggling with perception of professionals dismissing their point of view, and difficulty having their role taken seriously. Professionals, as noted in the literature review, have concerns about peer specialists in mental health. The perceptions some of our respondents have regarding professional response to them is consistent with professional worries reported by Chinman et al. (2006) and Carlson et al. (2001).

Our study is limited by its qualitative nature and small sample size. Thus, results should not be considered generalizable. It could be argued that only CPS who had complaints agreed to participate. However, we believe we obtained a reasonably representative group based on our knowledge of the small number of CPS in the areas we surveyed and our attempts to approach all of them. We did obtain a purposive sample of CPS employed within urban and rural areas working in eight different organizations. One of these organizations was completely peer run and managed. The remainder were traditional mental health agencies, but two offered programs primarily staffed by CPS. This helps give a nice overview of the variety of contexts where CPS may work. Although the

sample provided as much variation in region and workplace as we could possibly obtain, caution is still necessary when considering the findings.

The results do point to questions that need more answers. First, it is important to investigate in future work whether we can create and test an instrument to measure CPS experiences using our results. It would be useful to develop a quantitative tool that can be piloted and then utilized to capture data from a larger group in order to assess whether the experience of the agency culture and professional attitudes as potentially limiting and marginalizing CPS work is shared by others. Second, it would also be interesting to interview professional providers who work with CPS to obtain their perceptions. Third, many respondents noted that the organizational context was an important facilitator. Research does show that a certain kind of organizational culture is evident in mental health agencies that have clients who report most perceived support for their recovery (Clossey & Rheinheimer, 2014). It would be interesting for future work on CPS to ascertain if a certain type of organizational culture is also evident in agencies where CPS appears highly supported. Finally, the CPS respondents feel satisfaction in their work. It may also be important to assess in future work whether the experience of such satisfaction buffers the negative work experiences of marginalization by professionals or organizations.

This study fills a gap in knowledge about the experience of CPS work from the perspectives of the workers themselves. The Mental Health Recovery Model offers a socially just reformation of the provision of mental health services. Therefore, as Lietz, Lacasse, Hayes, and Cheung (2014) and Carpenter (2002) observe it is an important approach for social work to embrace due to its consistency with our professional values. As recovery approaches advance and are found to be evidence based, concerned providers and administrators need to be mindful of the agency context. These services work best when the context is supportive and enables optimal implementation (Clossey & Rowlett, 2008; Clossey, Mehnert, & Silva, 2011). CPS work is an important addition to the recovery repertoire. Understanding the barriers and facilitators to this work allows providers and administrators to address these issues so the service can be as effective and beneficial as possible.

References

- Anthony, W. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, 16(4), 11–23. doi:10.1037/h0095655
- Boyle, M. (2006). Developing real alternatives to medical models. *Ethical Human Psychology and Psychiatry*, 8, 191–200. doi:10.1891/ehpp.2006.8.issue-3
- Brydon-Miller, M. (2003). Participatory action research: Psychology and social change. *Journal of Social Issues*, 53, 657–666.
- Brydon-Miller, M., Greenwood, D., & Maguire, P. (2003). Why action research? *Action Research*, 1, 9–28. doi:10.1177/14767503030011002

- Carlson, L. S., Rapp, C. A., & McDiarmid, D. (2001). Hiring consumer-providers: Barriers and alternative solutions. *Community Mental Health Journal*, 37, 199–213. doi:10.1023/A:1017569913118
- Carpenter, J. (2002). Mental health recovery paradigm: Implications for social work. *Health & Social Work*, 27, 86–94. doi:10.1093/hsw/27.2.86
- Casstevens, W. J. (2010). Social work education on mental health: Postmodern discourse and the medical model. *Journal of Teaching in Social Work*, 30, 385–398. doi:10.1080/08841233.2010.515920
- Chinman, M., Young, A. S., Hassell, J., & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research*, 33, 176–195. doi:10.1007/s11414-006-9009-3
- Clossey, L., Mehnert, K., & Silva, S. (2011). Using appreciative inquiry to facilitate implementation of the recovery model in mental health agencies. *Health & Social Work*, 36, 259–266. doi:10.1093/hsw/36.4.259
- Clossey, L., & Rheinheimer, D. (2014). Exploring the effect of organizational culture on consumer perceptions of agency support for mental health recovery. *Community Mental Health Journal*, 50, 427–434. doi:10.1007/s10597-013-9681-8
- Clossey, L., & Rowlett, A. (2008). Effective organizational transformation in psychiatric rehabilitation and recovery. *Journal of Social Work in Disability & Rehabilitation*, 7, 315–339. doi:10.1080/15367100802487614
- CMS (2007). Department of Health and Human Services. State Medical Director Letter (SMDL) 07-011.
- Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006a). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 32, 443–450. doi:10.1093/schbul/sbj043
- Davidson, L., O'Connell, M., Tondora, J., Styron, T., & Kangas, K. (2006b, May 1). The top ten concerns about recovery encountered in mental health system transformation. *Psychiatry Online*, 6. Retrieved from <http://journals.psychiatryonline.org/article.aspx?articleid=96653>.
- Eiken, S. & Campbell, J. (2008) *Medicaid coverage of peer support for people with mental illness: Available research and state examples*. Centers for Medicare & Medicaid Services, Baltimore MD: Thomson Reuters.
- Frost, L., Heinz, T., and Bach, D.H. (2011). Promoting recovery-oriented mental health services through a peer specialist employer learning community. *Journal of Participatory Medicine*, 3. Retrieved from <http://www.jopm.org/evidence/case-studies/2011/05/09/promoting-recovery>
- Goldberg, C. (2007, June 8). Mental patients find understanding in therapy led by peers. *The Boston Globe*.
- Gordon, S. (2005). The role of the consumer in the leadership and management of mental health services. *Australian Psychiatry*, 11(4), 352–355.
- Grant, E. A., Reinhart, C., Wituk, S., & Meissen, G. (2012). An examination of the integration of certified peer specialists into community mental health centers. *Community Mental Health Journal*, 48, 477–481. doi:10.1007/s10597-012-9519-9
- Hogan, M. F. (2003). New freedom commission report: The president's new freedom commission: Recommendations to transform mental health care in America. *Psychiatric Services*, 54, 1467–1474. doi:10.1176/appi.ps.54.11.1467
- Johnson, G., Magee, C., Maru, M., Furlong-Norman, K., Rogers, E. S., & Thompson, K. (2014). Personal and societal benefits of providing peer support: A survey of peer support specialists. *Psychiatry Online*. doi:10.1176/appi.ps.201300113

- Kemp, V., & Henderson, A. R. (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal*, 35(4), 337–340. doi:10.2975/35.4.2012.337.340
- Lietz, C. A., Lacasse, J. R., Hayes, M. J., & Cheung, J. (2014). The role of services in mental health recovery: A qualitative examination of service experiences among individuals diagnosed with serious mental illness. *Journal of the Society for Social Work and Research*, 5, 161–188. doi:10.1086/675850
- McCann, T. V., Clark, E. L., Baird, J., & Lu, S. (2008). Mental health clinicians' attitudes about consumer and consumer consultant participation in Australia: A cross-sectional survey design. *Nursing & Health Sciences*, 10(2), 78–84. doi:10.1111/j.1442-2018.2008.00388.x
- Mead, S. H., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25, 134–141. doi:10.1037/h0095032
- Miles, G., & Huberman, A. M. (1994). *Qualitative data analysis*. Thousand Oaks, CA: Sage Publishing.
- NVIVO qualitative data analysis software; QSR International Pty Ltd. Version 10, 2012.
- Ostrow, L., & Adams, N. (2012). Recovery in the USA: From politics to peer support. *International Review of Psychiatry*, 24, 70–78. doi:10.3109/09540261.2012.659659
- Padgett, D. (1998). *Qualitative methods in social work research: Challenges and rewards*. Thousand Oaks, CA: Sage Publishing.
- QSR International. (2012). *NVIVO 10 [Computer software]*. Retrieved from <http://www.qsrinternational.com>
- Rubin, A., & Babbie, E. R. (2008). *Research methods for social work*. Belmont, CA: Thomson Brooks/Cole Publishers.
- Russinova, Z., Griffin, S., Bloch, P., Wewiorski, N. J., & Rosoklija, I. (2011). Workplace prejudice and discrimination toward individuals with mental illnesses. *Journal of Vocational Rehabilitation*, 35, 227–241.
- Salzer, M. S., Katz, J., Kidwell, B., Federici, M., & Ward-Colasante, C. (2009). Pennsylvania certified peer specialist initiative: Training, employment and work satisfaction outcomes. *Psychiatric Rehabilitation Journal*, 32(4), 301–305. doi:10.2975/32.4.2009.301.305
- Soffe, J., Read, J., & Frude, N. (2004). A survey of clinical psychologists' views regarding service user involvement in mental health services. *Journal of Mental Health*, 13(6), 583–592. doi:10.1080/09638230400017020
- Strauss, A. L. (1987). *Qualitative analysis for social scientists*. Cambridge, UK: Cambridge University Press.