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Maja B. Smedberg

St. Catherine University

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The Integration of Peer Support Specialists: A Qualitative Study

by

Maja B. Smedberg, BSW

MSW Clinical Research Paper

Presented to the Faculty of the

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Committee Members

Katharine Hill, Ph.D. (Chair)

Melissa Hensley, Ph.D., LISW

Andrea Lee, BS

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

The integration of Peer Support Specialists (PSS's) into the mental health workplace presents both a challenge and an opportunity. For this qualitative study seven Peer Support Specialists were interviewed regarding their experiences in the workplace with coworkers and supervisors, as well as the strategies they utilized to integrate into their workplace. The transcripts of these interviews were analyzed for common themes. Some participants described successes of being utilized as a resource by colleagues and treated with respect. Many participants also described incidents of stigma and prejudice in their work environment coming from coworkers and supervisors, as well as other unique challenges related to being a Peer Support Professional. The themes identified mostly related to stigma in some form and were analyzed and discussed under the conceptual framework derived from Corrigan's (2005) work on the stigma of mental illness. The implications of this social justice issue for the social work field was explored and discussed, and the qualitative information garnered from this study may be utilized to facilitate the integration of Peer Support Professionals by providing better supervision and encouraging mental health professionals to challenge and speak out against the stigma and prejudice that exists within the mental health field.

The Integration of Peer Support Specialists: A Qualitative Study

People with mental illness, especially severe and persistent mental illness, are not well accepted as professionals in the mental health field. This is in sharp contrast to the chemical dependency field and many other fields where personal experience is accepted and, in some settings, even considered a strength. As a result of the stigma many mental health professionals who have mental illness choose to keep their diagnoses hidden in their professional lives in order to protect their reputation and career prospects. Those who do “come out of the closet” often only do so after they have comfortably established themselves within the field. Two prominent examples of this are Kay Redfield Jamison and Marsha Linehan. Both of these brilliant women have made important contributions to the mental health field informed by their own lived experiences of mental illness. Both of these women also hid their own mental health histories for decades, out of fear that the associated stigma would tarnish their reputations and hinder their work. It was only after they had more than proven themselves to be competent, even excellent, clinicians and researchers that they felt able to publicly disclose their personal mental health histories (Carey, 2011). Jamison wrote in her 1996 autobiography, in which she publicly disclosed her mental health history for the first time, that “I have no idea what the long-term effects of discussing such issues so openly will be on my personal and professional life, but, whatever the consequences, they are bound to be better than continuing to be silent. I am tired of hiding, tired of misspent and knotted energies, tired of the hypocrisy, and tired of acting as though I have something to hide” (Jamison, 1996, p. 7). This would seem to indicate that, at least for her, keeping her mental illness a secret had felt like a burden. Marsha Linehan is the creator of the increasingly popular Dialectical Behavioral Therapy, a treatment often prescribed for people with Borderline Personality Disorder, which was previously thought incurable (Carey,

2013). In a New York Times article in 2013 she finally very publicly disclosed that she had struggled with symptoms of Borderline Personality Disorder as a young adult, and that the treatments she has designed were at least partially based on her own experience. Describing her decision to publicly disclose she stated that “So many people have begged me to come forward, and I just thought — well, I have to do this. I owe it to them. I cannot die a coward” (Carey, 2011, p. 1). This statement indicates that disclosing was something that she resisted for a long time and that she was very afraid to tell the truth, to disclose her past struggles with mental illness. If high-profile, nationally renowned mental health professionals struggle with the decision to reveal their history of mental illness in spite of the costs of keeping it hidden, it must be exponentially difficult for the average mental health professional.

The creation of the Peer Support Specialist (PSS) position created an opportunity for people with mental illness to openly prove their worth in the mental health field and to bring a fresh recovery-oriented perspective to a field that is slowly changing. However, the limited scope of the role, relatively low pay, and the scarcity of implementation along with existing prejudice and stigma has in many settings created a challenge and tension. There has been resistance within the mental health field as the mere existence of a “peer” role challenges the separation of professionals and patients as different from each other, which some authors have suggested can create cognitive dissonance and fear in some professionals (Corrigan, 2005).

What constitutes a Peer Support Specialist (PSS) varies by country, state, and setting. The specific title also varies, ranging from “Peer Recovery Specialist” to “Peer Provider.” For the purposes of the literature review all manner of Peer Support Specialists are included and referred to as “PSS’s” in order to minimize confusion. However, the MN Department of Human Services lists the prerequisites for a Certified Peer Support Specialist as

“Must be at least 21 years old. Have a high school diploma or equivalent. Have or have had a primary diagnosis of mental illness. Have received or is currently receiving mental health services. Be willing to share their experience of recovery. Successfully complete the Department approved Certified Peer Specialist training and certification exam” (MN DHS). Typical Peer Support Specialist duties include providing information, resources, and support to people with mental illness, as well as leading groups and advocating for people with mental illness (MN Department of Human Services, 2013).

The existing literature on Peer Support Specialists is plagued with issues. Due to the relatively recent emergence of the PSS role compared to other mental health professions many of the studies are exploratory in nature. Others are what can only be considered program evaluations of specific implementations of the PSS role, although the researchers do not explicitly identify them as such. As a result, the findings often cannot be reliably generalized beyond that setting. The spotty implementation of PSS’s makes attaining an adequate sample size an issue, and many of the studies that make do with small sample sizes lack the protection of anonymity for participants. A significant portion of the existing literature was written abroad, mostly in England, Australia, and New Zealand, where cultural differences could make the results not generalizable to America. However, on the other hand, the stigma of mental illness in a broad sense has been shown to be pervasive across cultures. Much of the focus of the research to date has been on PSS’s effectiveness, which was necessary to establish in order for even the existence of the role to be accepted by professionals, agencies, and funders. Now that certified Peer Support Specialist services are reimbursable by Medicaid there is a stronger incentive for agencies to hire and utilize them. Non-peer identified professionals are increasingly being forced

to work alongside or with Peer Support Specialists. Like any integration effort it has sparked discomfort, fear, and resistance in the mental health field.

People with mental illness have historically been oppressed and denied a voice in both society and in their own treatment. Although the creation of the PSS role is meant to help remedy this voicelessness it also creates a unique dilemma, placing PSS's as a buffer between patients and other, non-peer professionals. While many studies focus on effectiveness or results, the integration of some of the first peer support specialists is something that ought to be documented as well. There are many important questions to be answered: Are PSS's treated as equals by other professionals? Are they accepted as colleagues? Do they feel a sense of belonging in their workplace? How often do they encounter stigma and prejudice, either directed at themselves or at other people with mental illness? Are their ideas and contributions to the field valued and taken seriously? Do they feel supported? How have those PSS's who have successfully integrated into a workplace accomplished this? What strategies have PSS's found to be effective when seeking to establish themselves as professionals in the mental health field? These are the questions regarding workplace integration that this qualitative study will try to answer, in PSS's own words.

To date some qualitative studies have examined this dynamic and attempted to give voice to the struggles faced by PSS's, but all of these studies fall short in terms of what can arguably be called cultural competency. Many unique communities of people lay claim to a "culture" that is uniquely theirs. Traditionally these "cultures" were defined by nationality, religious beliefs, and/or ethnicity. However, it is increasingly common for marginalized populations to lay claim to, and celebrate, a culture of their own. Some examples include LGBT culture and Deaf/Hard of Hearing culture. People with serious mental illness often seek out others like them for advice,

support, and companionship. Some people with serious mental illness gather at “clubhouses” or drop-in centers, while others connect at support groups or websites and chat rooms. In this way some people with mental illness have recognized and connected regarding their shared experiences. Although people with mental illness are as diverse as the general population they have a common experience of prejudice, stigma, discrimination, and the mental health system.

If serious mental illness is regarded as a sort of community having a culture, then cultural competency should be considered anytime a study is conducted involving people with mental illness. None of the existing studies have interviews conducted by people who identify as peers, by those who identify as people with mental illness. I hypothesize that this affects what PSS’s are willing to disclose, which in some cases likely has a small impact on the studies accuracy and in others a large impact. If researchers do not identify as “of” the group they are studying how can subjects trust that their words and experiences will be accurately interpreted? How will researchers even know what questions to ask and how to phrase them? Given the existing evidence in the literature that the implementation of the PSS role is fraught with tension, lack of education, lack of clear role definition, and stigma, how can PSS’s feel comfortable disclosing their negative experiences, knowing that their honesty could further spark retribution or exacerbate negative attitudes towards the PSS role? Straddling the divide between peers/clients and non-peer professionals can be a difficult and lonely task, requiring skilled diplomacy. The current study seeks to address and remedy these issues, giving PSS’s the safety of anonymity and the benefit of knowing that their interviewer (the researcher) is “of their kind” and will “get it.” This will hopefully lead to a more honest and accurate portrayal of the PSS role and the difficulties encountered, a more accurate representation of the PSS experience, and the discovery of strategies and factors that help ease the integration process for Peer Support Professionals.

This information can be used by agencies, leaders, and PSS's to more effectively implement the PSS role in the future.

Literature Review

There were some major themes that emerged from the relevant literature. The findings are summarized into the following sections based on those themes: barriers to PSS integration, positive experiences, the challenger role, and study recommendations and successful integration strategies. Included after these sections is a discussion of the strengths and limitations of the relevant research. Many of the studies included had additional findings, but only content relevant to PSS integration is included in this literature review.

Barriers to PSS Integration

Some of the common challenges that these studies found that PSS's faced seemed to be growing pains of a newly created position and poor planning within a field that even experienced clinicians find stressful at times. The oldest study found on PSS integration, by Dixon (1994), found that there was a lack of clear role definition, lack of structure, lack of peer support for PSS's, and high turnover of the PSS position. Berry et al. (2011), approximately 17 years later, found that there was still confusion surrounding the understanding of and expectations for the PSS role by all parties involved. Moran, Russinova, Gidugu, and Gagne (2013) investigated the difficulties encountered by 31 PSS's who were employed in varying settings at the time of the study. The authors analyzed and coded transcribed interviews to come up with common themes. They found that there were many difficulties encountered by the PSS's, including a stressful work environment, a lack of clear roles and job descriptions, and a lack of education/training. Migdole et al. (2011) described some of the challenges for the program they evaluated as PSS's

recurring mental illness and a stressful work environment that might trigger the PSS's symptoms. In a wide-scale survey of 92 Local Recovery Coordinators in the United States Veterans Affairs (VA) system, Chinman, Salzer, & O'Brien-Mazza (2012) found similar barriers, including role confusion, low pay, lack of appropriate training of PSS's, and difficulty finding and hiring PSS's.

A second theme in the literature was PSS's strained relationship with supervisors and coworkers due to differing ideologies, the feeling or opinion that PSS's were encroaching on established "traditional" (non-peer) mental health practitioners jobs and expertise, and in some cases outright stigma. Seemingly as a result of these issues many PSS's had a feeling of being different from their non-peer coworkers and they experienced the strain of trying to work within an environment of relational tension and conflicting values. Berry et al. (2011) wrote that although one of the PSS's they interviewed didn't express such concerns, "The second PSS worker, however, described major discrepancies between the PSS professional identity, the job description at interview, and the reality of the role; consequently, the PSS worker reported difficulty in sustaining peer values in the role" (p. 240). This seemed to indicate some pressure felt by the PSS to conform to the values and methods of the non-peer mental health professionals. Both the managers and the PSS's in this study also felt that the PSS's were perceived as different by their coworkers and many had "ambivalent attitudes towards PSS workers, including concern regarding their stability and confidentiality, and fear regarding a future where peer workers "take over the whole mental health workforce" (Berry et al., 2011, p. 241). Another one of the prominent themes found by Berry et al. (2011) was the strong identification of the PSS's with their occupation/role and their sense of being different from the non-peer professionals that they worked with in terms of the values they focused on as well as

the approach they used with patients/clients. They identified those values as the strengths-based approach as well as authenticity and the recovery model. Tsai (2002) wrote a first-person account of his experience as a PSS, and although he enjoys his job he reported that “I often feel different from the other staff” (p. 207). He also described feeling caught in the middle between consumers/clients and non-peer professionals, not quite belonging or being accepted by either group. He noted that when it comes to his coworkers, “being a consumer professional has helped build rapport with some and not with others” (Tsai, 2002, p. 207). On the negative side he reports that some of his coworkers do not seem to value his contributions and regard PSS’s as ineffective and a poor substitute for a non-peer mental health professional. As a result of all the difficulties he faces at work, Tsai goes to a psychologist to help him cope and deal with workplace issues effectively. In another first-person account by a PSS, West (2009) similarly described stigma coming from coworkers.

Although in some cases stigma is subtle, in others it is blatant. Moran et al. (2013) found that PSS’s described over hearing coworkers making prejudiced and stigmatizing comments about clients, a lack of recovery-oriented treatment, and prejudice directed towards the PSS’s themselves. The authors provided extensive direct quotes from the PSS’s they interviewed that painfully illustrate the deep-seated issues within the environments in which PSS’s were being employed. Some examples of participant quotes are: “they tend to make fun of clients outside of the appointment,” if I say something it may be negated as ‘no that’s tangential,’” “I am assistant director of recovery services, I am not the director, and my director doesn’t know anything about recovery. Not only does he not know anything, but he doesn’t even believe in it!” and “it’s hard to be a trail-blazer when you are the only peer on staff” (Moran et al., p. 285-286). The PSS’s

indicated that they felt invalidated by their coworkers and sometimes supervisors and looked down on because of their history of mental illness.

Similarly, Migdole et al. (2011) found that hospital staff had doubts that the Peer Support Program examined in that study could be beneficial. Jacobson et al. (2012) described the PSS workplace as “a context that mixed high expectations and stigma-based stereotyping and discrimination” (p. 7). These findings as a whole indicate that the PSS’s were often not well integrated or accepted as coworkers in their workplace and this was felt by both PSS’s, their managers, and their coworkers. Many of the difficulties that PSS’s faced pertained not to the job itself but to the relationship between the PSS’s and their non-peer coworkers.

Stromwall, Holley, & Bashor (2011) anonymously surveyed PSS’s and non-peer-identified mental health professionals on their perception of stigma against clients and PSS’s. They found that PSS’s perceived much more stigma against clients than the other professionals did. The PSS’s also perceived much more stigma against other PSS’s than the other professionals did. These results could indicate that PSS’s are more aware of prejudice towards clients and other PSS’s (Stromwall, et al., 2011) However, in another study of PSS’s by Stromwall, Holley, & Kondrat (2012) they had contradictory results, finding that non-peer professionals perceived more stigma than PSS’s did.

Positive Experiences

In contrast to the previous examples, in a few instances PSS’s described a supportive environment. Singer (2011), in his first-hand account of being “one of the first peer support providers in Ontario” on an ACT (Assertive Community Treatment) team, describes a very positive relationship with his coworkers and supervisors and credits “the positive attitude of my

workplace, a supportive manager, an excellent treatment team, and my own determination” as helping him to return to work after a relapse and 14 week hospitalization due to his Schizophrenia. Grant, Reinhart, Wituk, & Meisen (2012) recruited 59 PSS's in Kansas to participate in their study that consisted of the investigators verbally asking participants questions and recording their answers. They measured workplace integration, job satisfaction, and perceived organizational support with questions where responses were rated on a Likert scale. They found that the PSS's gave high ratings in all three areas, indicating that the PSS's were satisfied with their jobs, were well integrated, and perceived a high degree of organizational support (Grant et al., 2012). Salzer, Katz, Kidwell, Federici, & Ward-Colasante (2009) came to similar conclusions. They surveyed 57 trained PSS's working in Pennsylvania (also using a Likert scale) and found that the PSS's indicated that they had high job satisfaction and felt that they were respected and accepted by coworkers.

Although the benefits of PSS's for clients/patients is not itself a focus of this study, what is relevant is what non-peer mental health professionals, and coworkers to PSS's, perceive to be the benefits and deficits of the position, as well as the changes that the introduction of a PSS can have on an agency that might ease the integration of future PSS's and reduce stigma. Dixon et al. (1994) described the benefits of the PSS's as more effective engagement with clients, the knowledge from personal experience that the PSS's brought to the team, a reduction in stigma, and increased sensitivity of the team fostered by the PSS's. Migdole et al. (2011) described the benefits of a peer support program in a hospital as including the learning that medical students garnered from the PSS's, a stronger relationship between the hospital and the Peer Support Program itself, and psychological benefits for the PSS's, such as a feeling of mastery and improved self-esteem. The quantitative data also showed that the program improved the patient

experience, on average, but there was not a strong enough relationship for this to be statistically significant (Migdole et al., 2011).

The “Challenger” Role

One of the benefits to agencies that was described in some of the studies is that of the PSS’s being what Berry et al. (2011) described as “challengers.” In that study both the PSS’s and their managers seemed to feel that the PSS’s should be challenging the system, policies, practices, and their coworkers, effectively serving as advocates for the patient perspective. Their perceptions of their coworkers reaction to being challenged varied, with some bad and some good experiences and outcomes. The PSS’s implied that working with their coworkers to teach and influence them to be more recovery oriented was just as difficult and time consuming as working with clients. The managers praised the PSS’s ability to be “politically aware,” which appeared to mean their ability to be tactful when challenging others (Berry et al., 2011). They summarized the difficulties of this “challenger” role, concluding that the PSS’s in their study “were in a vulnerable position of having to challenge workers of a higher pay banding, often in a resistant environment, and with limited support” (Berry et al., 2011).

Similarly, Dixon et al. (1994) found that the PSS’s “have functioned as true patient advocates, reminding the team of the patient point of view” (p. 622). Migdole et al. (2011) described some of the goals of the PSS program they evaluated as to “work to ensure that patients in the psychiatric ED were treated with dignity and respect,” “challenge stigma against mental health consumers,” and “act as a liaison between hospital staff and patients,” in addition to the usual peer duties of offering support, information, and resources to patients (p. 4). Tsai (2002) reported that as a part of his work he has advocated for and sparked changes in policy at

his agency. West (2009), in another first-person account, described the many ways that she manifests the challenger role. She writes that, “I advocate for clients’ larger possibilities in staff meetings, I challenge stigmatizing statements made in the back rooms, I share updated information about recovery” and notes that “this ability to change attitudes and perceptions for both clients and other staff is unique to the peer support role” (p. 446). Jacobson, Trojanowski, & Dewa (2012) also noted the challenger role. They used activity logs, focus groups, and interviews to gather data on the PSS role. They eloquently summarized their finding of the challenger role, concluding that,

“There are two other process characteristics that are most apparent in the “invisible” work that peers do: challenge and compromise. Challenge refers to the promise (or threat) of change that peers bring to the status quo. Challenge is embedded in the very existence of the peer role, but is especially apparent in the work of advocacy and education/awareness building that they do. Compromise represents the ways in which peers must restrain or moderate challenge in order to maintain their legitimacy” (Jacobson et al., 2012).

The expectation that PSS’s be challengers of the status quo is significant as this is not usually included in the PSS job description and seems to be an extra duty for which they are not necessarily allotted working hours. It may be an unpaid activity that PSS’s work on/prepare for in their time off. It also may be an unpleasant surprise to PSS’s that enter the profession and undergo training with the expectation that their role is solely or primarily to provide direct services to patients/clients.

Study Recommendations and Strategies Utilized Successfully

Some of the studies gave recommendations based on their findings, while others solicited and summarized the recommendations given by the PSS's studied. The PSS's that Berry et al. (2011) interviewed emphasized the importance of their managers and coworkers having accurate perceptions of what they do and realistic expectations. Another recommendation was for peer support for the PSS's which was seen as quite important. One of the PSS's stated that "I seem to be the only one that's working in this pure peer role and that has, on occasions, felt a bit lonely" (Berry et al., 2011, p. 244). Moran, et al. (2013) ended their paper with recommendations designed to improve the PSS role and support PSS's be successful in their work. Most of these recommendations consisted of further training for PSS's to improve their skills and help them cope with workplace difficulties. None of the studies made recommendations for changes in the agency environment or additional training for workers other than PSS's, which is notable as the vast majority of the integration barriers exist outside of the PSS's themselves.

Migdole et al. (2011) was the only study where preparations were described as being made before a PSS was brought into the workplace. Key staff were designated "champions" of the program and staff concerns were discussed and addressed. Interestingly, the program did not hire trained peer support specialists, but instead interviewed and hired consumers and then put them in a training program. The PSS's were scheduled to work in pairs and also had received frequent support and supervision from the program coordinator. They did not conclude whether these approaches were effective, but they are notable as they are the only example of agency preparation contained in the literature.

Jacobson et al. (2012) found that the PSS's they studied utilized a variety of strategies in order to build and sustain positive relationships with their non-peer coworkers. They described these strategies as "forging collegiality" (Jacobsen et al., p. 7). These included a sort of cultural

competency that involved PSS's learning and understanding the culture of their work environment, managing expectations of the PSS role, helping their coworkers with their work and making themselves useful in general, and seeking advice or input from coworkers "to show respect or deference to other staff" (p. 7). They also found that PSS's made efforts to be friendly to and socialize with coworkers to help build a positive relationship.

Literature Strengths and Limitations

Many of the studies in this literature review were based on peer support specialists in one specific setting or program. These are essentially studies of specific implementations of peer support specialists so are not very valid or reliable, however, examined as a whole they contained some common elements and feedback. Although the programs varied in type, location, context, setting, role definition, and implementation of PSS's they did share some commonalities. All of the programs were historically composed of "traditional" (ie. non-peer) mental health professionals and the addition of PSS's was relatively new. Additionally, as noted before, the stigma of mental illness is practically universal and presumably present in some sense in all of these settings.

Dixon, Krauss, and Lehman (1994) authored the earliest program evaluation of PSS's integrated with non-peer identified mental health professionals. The authors were the medical director, program director, and the principal investigator of the experimental Assertive Community Treatment (ACT) team. Although the authors included a few quotes from PSS's the evaluation was clearly from the point of view of the authors and therefore may not accurately represent the PSS's experience.

Interestingly, the Berry et al. (2011) study included a section titled “Reflexivity” at the very end of their paper. This section states that one of the authors has been to many workshops and events relating to recovery and/or the PSS role. It also discloses that two of the other authors are mental health professionals, and that all of them have personal values in line with the recovery model. This is a curious inclusion given that a reader would not normally expect to see such a statement in a study. For example, in a hypothetical study on the symptoms of Schizophrenia it would seem redundant and irrelevant for the authors to note that they have been to many workshops and conferences related to Schizophrenia, that they were mental health professionals, that they believe in the scientific method, and that this could influence the authors’ interpretation of the data. It is generally presumed that the authors of studies are knowledgeable about and interested in their topic. Also stated in this section is that one of the authors has worked as a peer support professional, however there is no indication of whether participants were aware of this fact. This may be relevant because it might otherwise be assumed by readers that none of the authors have been PSS’s.

Another common limitation encountered in the literature was a small sample size of non-random participants, often a convenience sample. Berry, Hayward, and Chandler (2011) evaluated the experiences and feedback of only two peer support professionals and their two managers in one “Mental Health Trust,” which is a team that provides mental health services for a particular geographic area of England. Migdole, et al. (2011) do not explain how they gathered much of the anecdotal information in their program evaluation, nor do they explain their own involvement with the program, calling the validity of the information into question.

Much of the research that was not program evaluations was qualitative. This is understandable as research is still in the exploratory stage and the particular aspect of being a

peer support professional that this literature review focuses on, integration, is rather subjective and difficult to quantify. Some of the literature reviewed was first-person accounts. West (2009) and Tsai (2002) authored short descriptions of their experiences as PSS's. These are very reliable accounts of specific PSS experiences as they are written by PSS's themselves, but their generalizability is limited. Jacobson et al. (2012) used a combination of activity logs, focus groups, and individual interviews with both PSS's and their non-peer coworkers. This led to reliable conclusions as they cross-referenced the information they gathered to come up with themes and conclusions. These researchers also worked with an advisory committee that included some PSS members, increasing their influence on the direction of the study and perhaps leading to a more accurate analysis of the data.

Although Grant et al. (2012) had a sample of fifty-nine participants the construct validity of the measures they used is questionable, and the fact that the questions were read aloud and answers recorded by the investigators means that the participants were not provided with anonymity and may have been influenced. Salzer et al. (2009) also had a large sample, of fifty-seven participants, however the majority of these participants came from rural areas of Pennsylvania and a majority of them were white, thus not a very diverse sample. Stromwall et al. (2012) and Stromwall et al. (2011) are studies by two of the same authors conducted a year apart which resulted in contradictory results, shedding doubt on the reliability of their measurement tools.

However, some of these studies also contained strengths. Berry et al. (2011) interviewed participants separately and asked open-ended questions which may have allowed the PSS's more freedom to say what they wanted. The transcribed interviews were also analyzed with the technique of thematic analysis and the participants were given the opportunity to read the

author's analysis of themes and provide feedback on how accurately they felt their experiences were being represented. This likely resulted in a more accurate portrayal of their experiences.

Chinman et al. (2012) conducted a large anonymous survey of 92 Local Recovery Coordinators at local VA's across the nation. This is a strong sample, however, the fact that it was Coordinators that were surveyed rather than PSS's themselves, means that the results represent the perceptions and experience of the Coordinators, not the PSS's themselves. Their input is still valuable but not as relevant because of their distance from the everyday experience of PSS's.

Migdole, Tondora, and Silva et al.'s (2011) study was ground-breaking as it described the implementation of a Peer Support Program in the psychiatric area of an emergency department (ED) in the United States and this was the only program evaluation found in which PSS's are utilized in an acute medical or hospital setting. The evaluation is not scientifically rigorous as it is primarily based on the authors' observations and quotes gathered informally from PSS's. There is quantitative data gathered via patient surveys that shows that patients were on average more satisfied with their care on shifts when there was a PSS as compared to shifts where a PSS was not working. In spite of the limitations, the program evaluation contains valuable exploratory information on the PSS experience and the challenges and successes of PSS implementation.

Conceptual Framework

This study was heavily influenced by Patrick W. Corrigan's work on the stigma of mental illness. He is a prolific researcher of stigma and the author of the 2005 book *On the Stigma of Mental Illness: Practical Strategies for Research and Social Change* which summarizes all of

the research and theories applicable to the topic and comprehensively investigates it from every angle. Since there is a dearth of research on many aspects of the stigma of mental illness he draws on research on the LGBT population, a group he sees as very similar to people with mental illness in that they may choose to hide their sexual orientation/mental health status and that they are found within every segment of the population. His theories, especially on the stigma of mental illness among mental health professionals and the subtle ways that they perpetuate prejudice, is very useful in understanding the experience of PSS's attempting to integrate into the mental health field.

Corrigan (2005) reviews several models and theories that attempt to explain the process of stigma, including models based on sociology, social psychology, and other disciplines. Corrigan approaches stigma from a social justice perspective, writing that "Stigma represents a social injustice that deprives people of their humanity, leads to violence, and results in robbing individuals of the opportunities that are rightfully theirs" (2005, p. 6). He also points out that in spite of the perception of some that the stigma of mental illness has decreased, in fact, based on studies by "Martin, Pescosolido, & Tutch, 2000; Phelan, Link, Moore, & Stueve, 1997; Phelan et al., 2000" he concludes that "public fear of individuals has increased over the past 40 years" (Corrigan, 2005, p. 20). Corrigan even investigates the stigma perpetuated by mental health professionals during the course of treatment, coming up with three main types of stigma coming from professionals: dehumanization, infantilization, and lowered expectations (2005). Dehumanization is when a mental health professional views or treats a person with mental illness as if they do not have basic human qualities (such as feelings, emotions, and opinions) and rights. This could also take the form of treating a person with mental illness as a diagnosis rather than as a unique individual. Infantilization consists of treating a person with mental illness as if

they are a child or child-like. This includes patronizing or talking-down to a person with mental illness or treating them as if they are unintelligent, helpless, and needing the types of protection that children need (for example, someone to decide what they will eat and when). Lowered expectations can be related to infantilization and involves mental health professionals setting low standards for people with mental illness rather than encouraging and pushing them to their full potential. In some cases they may even discourage people with mental illness from pursuing goals, believing that the person is not capable of achieving them. This treatment can create self-stigma and perpetuate dependency among people with mental illness. Corrigan (2005) illustrates how even those trying to “help” people with mental illness can perpetuate stigma and gravely harm their patients. In addition, mental health professionals are subject to the same influences that spark prejudice in the general population, and education has been shown to be ineffective in mitigating stigma (Corrigan, 2005). He refutes the notion that people with mental illness might have diminished opportunities not due to stigma but rather due to low functioning as a result of their illness, citing a study by Link (1982) which Corrigan explains “found that, controlling for other variables that affect employment and income (marital status, education, age, and occupation), patient status has twice as large an effect on income and employment than psychiatric symptoms did” (2005, p. 133).

Corrigan does not investigate the specific psychological processes that lead to higher levels of stigma among some mental health professionals; however, his theories can be used to explain this phenomenon. For example, Corrigan (2005) describes the “just world hypothesis,” a need for people to see the world as a fair place in order for them to feel “safe and secure” (p. 105). The idea that someone with mental illness can suffer so much through no fault of their own is just too sad, so when mental health professionals encounter a patient that has suffered so much

for no reason they may rationalize that the patient must deserve it. They must be at fault for their illness, they must not want to get better, they must be a bad person. Mental health professionals also want to believe that they have the power to “help” people with mental illness, that their expertise can alleviate symptoms and perhaps even cure the illness. However, when in spite of the efforts of professionals a patient continues to be ill it may be more comfortable to blame the patient as not cooperating or not trying hard enough rather than to think that perhaps their expertise and “help” was not effective.

As mentioned in the introduction, the current research is undertaken with the philosophy that there must be cultural competence when it comes to research pertaining to people with mental illness. As the author of the present study I maintain that it is an integral asset to my research that I am “of” the group I am studying. I believe that my personal experience in the mental health field as both a consumer of services and a professional makes me ideally suited to undertake this research with the insight and sensitivity needed. I maintain that if you don’t live with a mental illness, the stigma of and discrimination associated with mental illness may be more difficult for you to see. Just like white people tend to “not see” racism and sometimes deny that it exists because it’s not happening to them, people who have not lived with severe mental illness often do not see the stigma and discrimination that happens, even perpetrated by well-meaning people. I also maintain that most people with mental illness are aware of this phenomenon and may feel that researchers who do not identify as having mental illness will not understand, or even believe, their experiences and concerns. Thus, this qualitative research study has the opportunity to shed light on the experiences of Peer Support Specialists and the challenges, roadblocks, and successes they experience as they attempt to fit into a field dominated by non-peer mental health professionals.

Methods

This is a qualitative study where Peer Support Specialists were interviewed regarding their professional experiences, the interviews transcribed, and the resulting data analyzed for themes and commonalities. A qualitative approach was selected in order to best represent participants' experiences and give them a voice, to describe their work and workplace in their own words. This approach fits best with the philosophy of this study and most accurately represents PSS's experiences by allowing them to speak for themselves.

Participants

The participants in this study were people who currently or formerly worked as Peer Support Specialists. In the context of this study it was originally a requirement that Peer Support Specialist participants needed to have completed training provided by the MN Department of Human Services and be certified as a Peer Support Specialist in order to be considered a Peer Support Specialist. However, this requirement was not publicized and was modified after several potential participants identified as not being certified. This modification was acceptable because of the lack of availability of the training cited by at least one participant and the nature of the role still growing and evolving. Since specific job titles and responsibilities vary based on setting, this study utilized part of the MN DHS' definition of what constitutes a Peer Support Specialist. As it states on the MN DHS website, a Certified Peer Specialist,

“Must be at least 21 years old. Have a high school diploma or equivalent. Have or have had a primary diagnosis of mental illness. Have received or is currently receiving mental health services. Be willing to share their experience of recovery.” (MN DHS).

The participants also currently or formerly provided direct services to clients/patients/consumers for which they were paid. People who served as a Peer Support Specialist on a volunteer basis were not eligible participants unless they had also provided paid services. Participants that had professional experience in a role other than as a Peer Support Specialist were instructed to answer the interviewers questions primarily based on their paid Peer Support Specialist experience. As mentioned previously, this study originally intended to exclude any participants who are “peers” (i.e. are a person with mental illness) but who are providing mental health services in a role other than a Peer Support Specialist role (such as a Nurse, Psychologist, etc.). Participants’ job title and/or job description were required to include the word “peer,” as reported by the participant and if peer status was not a requirement for a position then that position would not be considered equivalent to a Peer Support Specialist position. However, that requirement was waived because of a low response rate and the need for more participants. The participants’ specific job titles will not be revealed in this study in order to maintain confidentiality. In all instances in which the participants’ were directly quoted in the final paper whatever job title they specifically used (ie. “Peer Recovery Specialist”) was changed to “PSS” or “Peer Support Specialist.” This is due to the specificity of job titles to certain work settings and roles which could compromise participants’ anonymity. All other potentially identifying information such as name, age, and specific employment setting was also redacted before final publication.

Interview Questions

The interview questions that were asked can be seen in Appendix A. Questions were formulated by this author with the goal of obtaining the most relevant, unbiased information. In addition to these questions the author often asked follow-up or clarifying questions such as “Can you tell me more about that?” or “What happened next?” that were intended to elicit more

relevant information. In order to ensure that the questions asked would result in the most complete, relevant information the initial questions were reviewed with a colleague of the author who is a Peer Support Specialist. That feedback was utilized to refine the questions.

Procedure

Participants were recruited using a snowball method. The email sent to potential participants, which can be found in Appendix B, explained the purpose and objectives of the study, and asked people interested in participating to contact the author via email or phone. Those who received the email were also asked to forward the email to any other Peer Support Specialists they were aware of. The author sent the recruitment email to Peer Support Specialists who were found via agency websites (where they were listed as employed as a peer specialist at that agency) as well as to key contacts within the Peer Support Specialist community who forwarded it on to possible participants. Potential participants who then contacted the author were screened for eligibility, provided with an informed consent form via email, provided with the interview questions they would be asked, and were given the opportunity to ask the author any questions they had via email or phone. All participants who then agreed to participate arranged a time for the interview to take place. The author originally intended to conduct interviews in person but found that in practice it was easier and preferred by participants to do phone interviews. All interviews were conducted by the author. Before the interviews began the author again reviewed the informed consent with the participants and obtained a signature, as well as gave participants another opportunity to ask questions or express concerns. They were informed that they could decline to answer any question. The participants were also informed that they could end the interview at any time, for any reason, and could also rescind their participation in the study up to a week after their interview took place. Participants were

provided with information on supportive resources, Appendix C, which they could utilize if the interview raised upsetting emotions.

Audio of the interviews was recorded using a recording device that captured sound only. The author/interviewer wrote down observations on tone of voice, etc. which the audio recording could not capture in a transcribed format. These notes and the recording device were kept in a secure location to which only the author had access at all times. During the transcription process the recordings were kept in a locked drawer in the author's home. Each interview was transcribed by the author. After the transcription process was completed the audio recordings were destroyed. Only the study's author and committee members Andrea Lee, Melissa Hensley, and Katharine Hill may see the transcribed interviews. Direct quotes of participants were edited, when necessary, to conceal the participants identity. This editing is noted in the final paper by italicizing all portions of quotes which were modified. In some cases extraneous words and sounds such as "um" or "uh" were removed from quotes, and this is not noted as it does not change the meaning of the quotes.

Data analysis

The type of data analysis utilized for this study was an interpretative approach, which Berg (2012) described as analyzing "expressed layers of meaning" and to "organize or reduce data in order to uncover patterns of human activity, action, and meaning." (p. 239). The method chosen, in practice has both quantitative and qualitative aspects. The qualitative aspect was the coding itself and the categorizing of pertinent themes. A quantitative approach was used when counting the presence of certain keywords and themes. The transcript was first analyzed by

looking at answers to each question individually. Responses were then compared and contrasted, with thematically similar responses grouped together under a common theme.

After responses were compared and contrasted by question asked the total content of the transcribed interviews was reviewed. Each distinct section of a sentence that conveyed an idea was individually compared and contrasted with other ideas and sentiments expressed by other participants. Information in the transcript which was irrelevant to the study topic or repetitive was deleted as participants' words were distilled down to the shortest possible quotes which still transmitted their intended meaning. In line with the conceptual framework the author wished for the participants own words to be used as much as possible. As a result, the findings section contains many lengthy quotes, to illustrate themes in the participants own language.

Protection of Human Subjects

All of the participants were people who publicly identify as Peer Support Professionals in their workplace, to clients, in employee directories, and in some cases on their agencies websites. Their job title and employment status are not confidential so receiving an invitation to participate in this study did not reveal any previously unknown information about them. However, for both convenience and in order to protect the anonymity of participants' potential participants were contacted via email. This allowed them to choose to open and view information on the study in whatever setting they preferred. No one knew (besides the author) whether they chose to participate or not, unless the participant told them. They could also choose when, where, and how to contact the researcher given the options of email or telephone call. Other protections to maintain anonymity (i.e redaction of identifying information, securing of audio recordings) were covered in previous sections.

Participants were provided with both an informed consent form (Appendix C) and the interview questions before the interview took place. They were also given at least two opportunities (at initial contact and immediately before the interview took place) to ask questions and voice any concerns about their participation. Included in the informed consent was the information that if at any point they wished to end their participation, for any reason, they may do so without any repercussions.

Although some of the interview questions had the potential to prompt the participants to recount upsetting events there were also questions that had the potential to prompt them to recount positive experiences. The experiences they recounted took place in the context of their profession and employment, and recounting the events was presumably less upsetting than experiencing them, something they have survived. Talking about their negative experiences may have even provided some relief and given participants an opportunity to emotionally process events. Given that Peer Support Professionals come from a population that has historically been oppressed and silenced, being given the opportunity to make their voices heard was perceived very positively by some participants. Some participants also felt positively about the possibility that their feedback may be used to improve the experience of future PSS's. Since participants were given the interview questions ahead of time they had time to think about what their responses might be and to decide what they would like to disclose and what they would not like to disclose. They were made aware that they should only share what they felt comfortable sharing and that they could decline to answer any of the questions. In case the interview did elicit negative or upsetting emotions in a participant they were provided with a list of resources where they could find support. This included immediately available help, such as crisis lines, as well as the walk-in counseling center.

Findings

Participants

There were seven participants recruited for the study, six female and one male. In order to protect the confidentiality of the one male participant all of the participants will be referred to using female pronouns, such as “she” and “her”. Three of the participants worked in Community Support Programs. The other workplaces that the participants worked in were a clubhouse, a crisis stabilization unit, an intensive residential treatment facility for women, and one participant had experiences working in two different settings at different times. For two of the participants a Peer Support position was created in order to hire them specifically, as they had prior relationships with their employers. One participant was a member for many years at the clubhouse where she was eventually hired. Another participant worked in a small rural area and was acquainted with her employer from her prior work. As she explained, “they were aware that they did not have a lot of people in the area that had had the training, so selection wasn’t an issue, they kind of catered to me.” Another participant was the second Peer Support Specialist at her workplace and believes that the position started “a few years” before she was hired. Yet another participant estimated a Peer position being at her workplace for 4 or 5 years, a third participant estimated 6 to 7 years, and a fourth participant stated that before her there was another peer who worked there “about a year.” One participant was the very first peer at her first workplace (and the only peer in a brand new setting for whom the position had not been created specifically) and was the 2nd peer on an ACT team, with the previous peer having been there for about 5 years.

Participants' job titles were mainly different variations of Peer Support Specialist and Peer Recovery Specialist. The only participant whose job title did not include the word "peer" was hired in a different capacity in a mental health setting. However she considered her peer status and certification training as an integral part of her work and presents and refers to herself as a Certified Peer Support Specialist so was considered eligible for the study.

The participants reported that they worked in their positions for between nine months and four years. Only one participant held two peer support positions consecutively. In conducting the interviews it became necessary for many of the participants to talk about their employment experiences before or after they worked as Peer Support Specialists in order to adequately explain the context that they were coming from and to compare and contrast settings.

Participant Qualifications

Many of the participants had qualifications above and beyond that required of a Peer Support Specialist. While the MN DHS standards require a high school diploma or GED and the certification training only four of the seven participants had completed the certification, and four participants had advanced degrees. Three participants had Masters Degrees in social science-related fields. Two participants were Registered Nurses. One participant cited extensive volunteer experience in the mental health field and trainings as additionally preparing them for their work as a Peer Support Specialist.

Work Environment

In response to the prompt to describe their work environment many of the participants described the function of their workplace, the services provided, and the physical setting.

However, six out of the seven participants described their work environment as primarily positive, while one participant described one of their work environments very negatively.

Participant 1 described her work environment using the words friendly, busy, and hectic. She stated that “my coworkers and staff, they’re really laid back and very supportive so it’s a comfortable work environment.” Participant 2 also described her work environment as “comfortable” as well as “pleasant” for both clients and staff. She also cited an important detail about her work environment as that employees were permitted/encouraged to take time off of work for both physical and mental health. She described a coworker being hospitalized for mental health issues recently and stated that “she has the support of the whole team behind her and she knew that.” Participant 3 also described a supportive environment and talked about how she appreciated working primarily with other Peer Support Specialists, as they were especially supportive of each other. She stated that they, “were understanding of where you were at and... there was a time when I had a breakdown and came into work to talk to my coworkers just to get their understanding... I remember one time that I had a panic attack or something and they were wonderful.” Participant 4 also talked about feeling “supported” and contrasted her current workplace being a non-profit with her previous employment in “the corporate world”, stating that it was a “very welcome” change for her.

One participant described her work environment at a hospital as “very self-directed” and “confusing and overwhelming.” Some of the problems she cited were an inaccurate and “basic” job description, a lack of feedback, and what they described as an attitude of “just go out and do your peer stuff and... just to get on with it.” In contrast she described her later work environment with an ACT team as “very independent” but within a structure and a schedule. This participant

also liked the prevalence of “instant feedback” that was available because they had daily “team meetings.”

Relationships with Supervisors

Four of the participants had only positive things to say about their supervisors, and the common themes among those were that their supervisors were supportive and approachable. Participant 1 described her relationship with her supervisor as “very good” because her supervisor is “really supportive” and “treated me like an equal.” Participant 2 expressed a lot of admiration for her supervisor and described their relationship as “amazing” because “I trust her implicitly.” She described her supervisor as patient and accommodating with her learning disabilities, as well as very creative, patient, supportive, “gifted at what she does,” and “my advocate.” She praised her supervisor’s openness to feedback and her approachability, stating that “everything’s democratic... she consults me and my coworkers when any decisions are made with anything that has to do with programming” and that “I feel like I can go to my supervisor with anything.” Participant 2 also stressed the importance of a supportive supervisor, stating that “You have to know that that person is gonna have your back and support you and not be afraid to take on other staff people if they’re not treating you well.” Participant 6 similarly praised the approachability of her supervisor, stating that “she has an open door policy and it’s very easy to just pop in and talk to her, not just about challenges with how to work with clients but just kind of the stress of being on such a team that’s very intense and has a lot of things going on.” Participant 4 described her relationship with her supervisor as “really good” because she was very supportive, understanding, and, once again, approachable because she has “really been there to answer questions and help out.”

Participant 7 described her relationship with her supervisor as “pretty good” because “she has really high expectations” which she described as both a positive and negative thing.

Participant 3 had two supervisors and described one as understanding and kind while the other supervisor was very critical and made her feel like “I couldn’t do anything right.” Overall participant 3 noted that even with the supportive supervisor things were “hard also because neither one of them had mental illness either, so it was a little hard to... be in such a role and not have someone who was understanding of the problems that we were dealing with peers.” None of the participants described their supervisors as peers or mentioned them having any kind of mental illness.

One Participant described her relationship with her supervisor as overwhelmingly negative, because she received little feedback and the feedback that she did receive was very delayed and often out of touch or not relevant for her work. This participant described feeling like they were “alone out there” and “my supervisor didn’t really have my back.” Another major problem was that “it just didn’t seem like they knew what a peer was supposed to do, or what it should look like.”

Relationships with Coworkers

The participants that described positive relationships with their supervisors also described positive relationship with their coworkers, although the words they used to describe the relationships differed. Participant 1 described her relationship with coworkers as friendly, laid back, supportive, and “very sweet.” Participant 2 stated that she gets along well “with the whole staff.” She described having an issue with only one coworker, because “she knows that I have the learning challenges that I have, she’s just not patient about it.” With other coworkers she felt like

she could ask them for assistance and overall she stated that “we have a great team.” Participant 5 described her coworkers as “very accepting of me” and stated that “they valued my opinion.” Participant 6 similarly stated that her coworkers “value what I say and seek out the peer perspective” and that their relationship consists of “mutual trust and respect.” Participant 3 worked primarily with other Peer Support Professionals, many of whom she had gone through the certification training with and as a result felt “very close” with because “they knew me inside and out.”

Participants 4 and 7 had mixed, but primarily positive feedback. Participant 4 described her relationship with her coworkers as good, but noted that she had a “different” approach from the previous peer which took some time for her coworkers to get used to. Specifically, she had higher expectations for clients and did not want them to “settle.” Participant 7 characterized her relationship with coworkers as “wonderful” and supportive, and stated that “there’s really only been a couple people that I’ve bumped up against.”

In contrast to all the other participants, one participant had primarily negative feedback about one of the settings where she worked. They felt that in a medical setting where they worked “there wasn’t really a relationship” with coworkers at all, because she “felt like an outsider,” there wasn’t a “consistent way” to communicate with other staff, she felt “seen and not heard,” and many of the staff didn’t understand the peer role or how to utilize her. In fact, in spite of emails sent and attempts to educate staff, many staff weren’t even aware of this participant or the services she offered and her supervisor “didn’t ever help me find how to overcome some of these barriers.” This participant is aware of at least one instance where a patient asked to see a Peer Support Specialist and was told that there wasn’t one.

The Effect of Being Both a Peer and a Professional

When asked if being both a peer and a professional affected their relationship with their supervisor or coworkers in any way, some participants described it as a strength, having a positive effect, while others described unequal treatment, coworkers feeling negatively about their peer status, and being stigmatized.

Two of the participants in describing their relationships with their supervisor and their coworkers notably cited prejudice and stigma as something that wasn't present. Participant 1 stated that her coworkers "are sympathetic to... mental health issues that I may have, at the same time they seem not to look down upon it... or think of themselves as superior or anything, so it hasn't been an issue where I've felt like less than an equal." Participant 2 stated that at her workplace "nobody looks down on me, nobody talks down to me... I'm just the same as everybody else." Participant 1 was also a client before she was hired at her workplace so she noted the positive change from being a client to being treated as a coworker and being "invited to staff parties" and "welcomed to the gang." Participant 2 noted that as a Peer Support Professional she uses a different vocabulary from her non-peer coworkers, referring to the people she works with as "peers" rather than "clients."

Participants 4 and 5 also had positive experiences, but differed from Participants 1 and 2 in that they did not note a lack of prejudice but rather cited only good things that they felt resulted from their dual Peer and Professional status. Participant 4 felt that being both a peer and professional was "an advantage" for the relationship as she is able to share her experiences and help coworkers "see the possibilities of recovery." She feels that this has been "good on both sides." Participant 5 stated that being both a peer and a professional was "very beneficial" for the

relationship because it “put a very much positive slant on things” and “it added to my credibility, the fact that I had been a provider as well as a consumer. That I could see the issue from both sides of it.”

In contrast, Participants 3 and 6 described being looked down upon because they were peers. Participant 3 worked primarily with other Peer Support Professionals when she worked as one so did not feel treated differently in that setting. However, she no longer works as a Peer Support professional and has found that her peer status affects her relationship with coworkers much more now that she works as an RN on an inpatient mental health unit. She stated that “I feel that the nurses a little bit look down on me... as if I’m not the same level that they are. I’m pretty transparent, and I feel like they look at me like I’m not as stable as they are or not as ... strong in my nursing as they are... I feel like if I say that I have a mental illness, a severe and persistent mental illness that I deal with every single day... that makes me less of a nurse.” Participant 6 similarly described negative attitudes regarding peers in a hospital setting, stating that “I just did not feel respected.” This participant described instances where “staff flat out said because you’re a peer you can’t do this” as well as times when her competence was questioned with questions such as “would you be able to handle seeing something like this, or would you get triggered and not be able to professionally do your job?” Overall she said that at the hospital the perspective was “because you have the title of Peer you’re not as capable as other staff” and that as a peer she was viewed as “a liability.” In contrast, working with an ACT team she has felt the complete opposite, describing it as “because you have the title of Peer these are all the great things you bring to the table that the other staff can’t bring to the table, and... they kind of celebrate the strengths that that brings.”

Participant 7 stated that she has a “positive” relationship with her coworkers and doesn’t think that being both a peer and a professional negatively affects their relationship. However, she also noted that as a Peer Support Professional she doesn’t have to do as much paperwork and she says of her coworkers that “sometimes they think I’m not as capable of doing it.”

Integration Challenges

When asked if they experienced any difficulties or challenges integrating into the mental health workplace as Peer Support Professionals Participants 4 and 6 reiterated the issues that they had mentioned in describing their work environments and their relationships with supervisors and coworkers. Participants 1 and 2 talked about the various things they needed to learn as new employees. Participant 1 had not had the Peer Support Specialist Certification training so she “knew very little about the HIPPA laws” and learning about agency “protocols” as well as “a big transition for me.” Participant 2 similarly said that “it was just a matter of learning the things I needed for the job.”

Participant 3 said that she “struggled with the fact that it was not a very professional setting.” She described an instance of another Peer Support Specialist writing a case note that primarily consisted of her opinion about the client. She noted was not what they were trained to do as PSS’s and her supervisors did not back her up when she brought her concerns to them. She also struggled with the role being “ambiguous” once she was “out in the field” and stated that was “uncomfortable.”

Relationship Strengthening Techniques

When asked what they have done that strengthened their relationships with their coworkers, several of the participants talking about working hard. Participant 1 said that “I go

out of my way, I come in early... I will put in the extra effort... they can see that I really put forth 110% ." Participant 4 similarly said that her coworkers "see that I am very dedicated, a very hard-worker."

Participant 3 talked about facilitating groups, which her coworkers dislike doing, as something that gains their appreciation. She also characterized how she explains her mental illness and it's symptoms to coworkers as important. For example, she said that, "I'll say there will be times when I will have so much anxiety that I cannot hear what they're saying or something, and I will say to them, ok I need a moment, and... because I can't absorb what you're saying because I'm having so much anxiety, and they usually deal with it pretty good when I say it like that." Participant 4 similarly said that talking about her "life experiences with mental illness" helps her coworkers "understand a little better."

Participants 3 and 7 cited expressing appreciation for their coworkers as beneficial, with Participant 3 noting that, "thank you's are really beneficial, because I couldn't do my job without their help" and Participant 7 citing giving "positive feedback." Other miscellaneous strategies and techniques that individual participants mentioned were brainstorming with coworkers, being friendly, "showing that passion and that you care," and bringing food for coworkers.

Advice for Peer Support Professionals Getting Started

Participants 1, 3, and 7 talked about the importance of self-care and not taking on too much. Participant 1 advised that "as somebody with a mental health issue you really have to be quite aware" of the emotional "toll" of the work and that you should "take care of yourself outside of work." Participant 3 advised taking it slow and said that she wasn't sure if, "having a

mental illness that I would ever be ok working full time in my position” and so she works part-time.

Other Themes

Boundaries and Complicated Roles

Participants 1 and 3 mentioned boundaries and the complicated relationships they have with their peers/clients as something that was difficult and not necessarily addressed as much as they feel it should be. As Participant 1 put it, “you’re staff so you’re looked up to as authority but then you also have this friendship aspect with the people, and so it’s a really slippery slope... there’s just all these different roles that you’re playing simultaneously... my relationship with the people I serve is a really complicated role.” Participant 3 expressed similar feelings and said that it was difficult because as a PSS, “In the situation where I worked we were supposed to... be friends with them, I mean kind of ... but at the same time you’re not supposed to be a friend.”

Resource and Challenger Role

Four of the participants talked about being used as a resource by their coworkers. Participant 2 cited being used a resource by her coworkers as something that made her feel valued and accepted in her workplace. Participant 1 said that she had explained things such as mania and rapid cycling to a coworker from the perspective of “experience from seeing friends and other stuff.” Participant 6 noted that “With the daily team meetings I’m always called upon to provide my insight and to add to the discussion and, you know, they value what I say and they kind of seek out the peer perspective.” Participant 7 similarly said that her coworkers “ask me about what I’ve experienced” and that they “use me as a resource of finding different resources for people.” She also noted that she empathizes with the clients “and I bring that empathy into

staff meetings.” Participant 1 talked about a different but similar role of not being used as a resource exactly but rather “as a poster child.” She explains that “I’ve been put like behind a podium, I’ve been put on panels, I’ve been put in newspaper articles, I’m like the success story” with the goal of breaking down stigma. “And so I’ve been more of a poster child than a resource for learning about mental health stuff.”

Gratitude

Gratitude and feeling “lucky” was a common theme, with three of the participants expressing such feelings. Participant 2 felt “lucky” that “the environment I’m in is so supportive.” Along the same lines, Participant 7 also expressed feeling “lucky” that her coworkers are “very supportive, which I don’t think happens everywhere.” Participant 3 expressed a perspective that is perhaps unique to people with disabilities, that “I just feel so lucky to have a job. I didn’t think I’d ever be able to have a job... I mean 10 years ago I never thought I was going to be a nurse working at a hospital. I spent weeks on end not being able to leave my house and shutting... completely shut down from mental illness, from OCD, and anxiety, so yeah I just feel lucky. I just, I love being able to work.”

Healthier Working

Participants 1 and 2 talked about being healthier since they started working as Peer Support Specialists. Participant 1 explains that “part of the role of being a peer support is leading by example, you know, you are an example of success, so it’s kind of... kept my behavior more modified I guess you could say, so I’ve taken better care of myself.” Participant 2 also talked about being healthier but for different reasons. She had previously worked as a cashier and found it very stressful “because of the, you know people higher up from me who... when they were

teaching me something new, you know, I needed more than one shot at it and they were very impatient and for many many reasons I was having panic attacks all the time.” In contrast she has not found the work environment and her role as a Peer Support Specialist as stressful but rather very supportive and as a result “I’ve actually been really healthy in these 2 years... which is kind of funny because my psychiatrist, my parents, everybody said I wasn’t gonna make it 6 months.”

Heard from Other PSS’s

While the majority of the participants didn’t feel discriminated against in their workplace because of their mental illness, Participant 2 talked of such treatment happening to other PSS’s that she knew. She stated that “I think I’m very fortunate. Because I’ve had friends that started places and left. Because they were treated with so much disrespect and not enough credibility and everything... They were given menial jobs to do, you know things that nobody else wanted to do they would give to the peer support.” In addition, “they didn’t like the language that peer support specialists learned to use” such as referring to the people they serve as peers, and “one person I know wanted to stress that and they were shot down by another coworker saying, they’re not peers they’re clients.” Another Peer Support Specialist coworker “has personal things that at her last job she was really disrespected for and they treated her very poorly.”

Dual Peer and Professional Roles

Three of the participants expressed feeling like at times they were not regarded as really having mental illness. Participant 3 described feeling like her severe and persistent mental illness was minimized by her boss because “I said the reason I want to work in this field is because I also have a mental illness... so she said to me... “that’s fine, we all have... we ALL have certain mental illnesses, we’ve all dealt with depression and anxiety.”” Participant 7 also talked about

her boss, stating that “I think she forgets that I have a mental illness sometimes.” At one point she took time off to receive treatment for her mental illness and she said of her coworkers that “I would’ve thought that they connected the dots but they... she hadn’t ... I mean, I think at that point it made them realize that I am the peer support specialist” and not just like her non-peer coworkers. Participant 4 said that “I’ve told people one on one about my experience and they’re like “really?” I mean somehow I guess they think that I didn’t go through the hospitals and the ECT treatments and everything that I’ve gone through because I’m peer support. Well, guess what? I have gone through it.”

Participant 3 felt very conflicted because she was expected to be purely one thing in her role as a peer and that did not reflect her experience and who she was. She found this to be a problem when she began working as a nurse as well, as she was expected to NOT be a peer or identify as a person with mental illness. As she explained,

“working in peer support I was never supposed to tell anyone that I was a nurse. Well, being a nurse is a big part of my life. I think that was almost a really big reason that I left... people were afraid that if I said that I was a nurse then people would be coming to me to provide medical care or something for them and never did that one time come up. And now working in nursing my boss told me that I am supposed to not share with people and... hold back my position in life or whatever. . . . she offered me the job and she said “I want you to make sure that you understand that I want you to refrain from, you know, telling people your story or being really open about it.” And I struggled with this constantly, in both settings I struggled because I really just am who I am and neither one of them are separate. In the setting where I work now, I feel that being a peer support specialist is so beneficial that I don’t think my boss is letting me let it out there as much

as I could. However, when I'm teaching a group... I always start off by saying that I'm a peer support specialist... and... my training as a peer support specialist makes me a different kind of nurse. ... I don't know if someday I might get in trouble for doing that but I just... I think it's essential. I don't know how to talk to patients without saying I know some of what you're saying or this is what I've tried... not like I understand you, I don't say that, just that I know how hard at times this can be because I've been in similar situations. ...and I'm never going to let that go, even in the nursing setting. Even if someday I become a nurse practitioner I will still be a peer... I've made that a very big goal in my life.

Participant 6 also noted the division of roles as being either a peer or a non-peer role, stating that "hopefully the future of mental health care and the model of having people with the same experiences kind of sharing that and supporting others, I just personally hope that it's not limited to requiring the role of peer but that it can just be a social worker, a case manager that has had some of the same experiences."

Discussion

This qualitative study was designed to explore the barriers that Peer Support Professionals face in integrating into the Mental Health Workplace as well as successful strategies and other factors that eased integration. Seven qualitative interviews were conducted with Peer Support Professionals. They were asked about different aspects of their experiences as PSS's in the workplace, including their work environment, integration into their workplace, relationships with coworkers and supervisors, the effect of their peer status, and things they did that strengthened their relationships with coworkers. The interviews were transcribed and in

addition to responses to the different questions being compared and contrasted, common themes that popped up throughout the interviews/transcripts were described and analyzed. Some of the types of stigma and prejudice identified as coming from coworkers and supervisors are those that Corrigan (2005) identified as commonly perpetuated by mental health professionals, namely lowered expectations, dehumanization, and infantilization. Of these three, only dehumanization did not seem prevalent.

Denials of Different Treatment

Several of the participants in describing both their relationship with their supervisor and their coworkers notably cited prejudice and stigma as something that wasn't present, suggesting that they were aware of the possibility of being treated this way, were aware of other peers being treated this way, and/or were treated this way in other settings or areas of their lives.

Additionally, although most of the participants denied experiencing stigma or prejudice because of their mental health history or peer status, many of these same participants at other points during the interview recounted instances of discrimination or differential treatment. For example, when participant 7 was asked if her being a peer affected her relationship with her coworkers she replied "no" but then later recounted feeling as if her coworkers don't think that she is as capable of doing paperwork as they are and described their awkwardness towards her after coming back from time off to care for her mental health. Although she gave her supervisor permission to ask questions about her time off and experience in a partial hospitalization program her supervisor declined to ask any questions and the entire thing was "brushed under the rug." This exhibits lowered expectations with regard to this participants' ability to do paperwork. The way in which the hospitalization was "brushed under the rug" suggests that the hospitalization may be viewed as something shameful by coworkers. That reaction is notably quite different from how

coworkers would react to a coworkers hospitalization for a heart attack or any other illness other than mental illness. It could also be viewed as a private matter, but the participants' comfort with talking about her experience and invitation to her supervisor to ask questions made it clear that she was not asking for privacy.

Participant 2 also characterized her role of being both a peer and a professional as having no negative effect, stating of her coworkers that "no one talks down to me," but then she also stated that one of her coworkers is not patient with her learning disabilities, which is apparently a negative effect of her having challenges that other workers do not have and may not be able to relate to. Participant 4 stated that being both a peer and professional is "an advantage" when it comes to relationships with her coworkers and supervisor but then also talked about how her coworkers seemed to have diminished expectations of clients and this caused some difficulty at first, until they eventually came around and "were on the same page." This appears to be the lowered expectations that Corrigan (2005) describes as one of the ways that benevolent stigma from mental health professionals manifests itself.

These findings suggest that although these participants may not identify as experiencing stigma they are describing experiencing stigma and prejudice from coworkers and supervisors. They may even be subject to it in even more subtle ways which they did not mention or recognize. This could be due to PSS's wanting to focus on strengths and positive experiences rather than negative experiences or challenges. Another possibility is that they view these types of situations as positive opportunities to educate and break down stigma. This could help them cope and feel more positively about the coworkers with whom they have to work. Corrigan (2005) also describes the phenomenon of internalized self-stigma, which could theoretically play

a role and could be further explored in future studies. The thoughts and feelings underlying these interpretations could also be further analyzed in future studies.

Supervision

The most commonly cited positive characteristics of the PSS's supervisors were that they were supportive and approachable. One participant stated that the relationship with your supervisor is crucial to your success as a PSS and will "make it or break it." Two participants mentioned that they felt that they could trust their supervisor to back them up and defend them if they were treated unfairly by other coworkers, a seemingly important quality. This is not something that employees who are not a part of a minority have to be concerned about and may not even consider. The participants who spoke very positively about their supervisors were also those that had the most positive experience overall, suggesting that a positive relationship with a supervisor may help with overall integration, perhaps by setting an example or tone of interaction with the peer for other coworkers or by exhibiting official approval or sanction of the peer. Corrigan (2005)'s research supports interaction with someone with mental illness, as an equal, under circumstances sanctioned or sponsored by an authority figure or leader, as one of the most effective ways of decreasing stigma.

It is also notable that none of the PSS's were supervised by someone who also identified as a peer. This is unprecedented for a field of work, as one generally finds that people are supervised by someone who is more of an expert than they are in an area rather than having less knowledge of an area. Given that PSS training and the PSS role differs from that of other, non-peer professionals in the mental health field there is no evidence that a non-peer supervisor is qualified to supervise a PSS. At least one participant describes lack of peer status as a barrier to

good supervision, and another describes very poor supervision being provided by someone who they state does not understand the PSS role.

Resources and Challengers

Although the literature indicated that some PSS's took on a "challenger" role, only one of the participants in this study described performing such a function. However, participants were not specifically asked about this so it may be something they do but did not spontaneously mention. Regardless, a similar role that many participants mentioned was being utilized as a resource for their colleagues, either as a resource for information, a resource for the "peer perspective" or, as one participant put it "a resource for other resources." This "resource" role is different from the challenger role but also similar in the sense that in both roles the PSS is serving to educate other coworkers. The difference lies in that the challenger role is more confrontational whereas the resource role is more benign. The resource role could perhaps be a precursor to a challenger role that a PSS may take once they are more established or feel secure in their position.

Qualifications

Five of the seven participants had qualifications far beyond that which was required or expected of them as a Peer Support Specialist. Given their qualifications it is notable that they chose the career of a Peer Support Specialist rather than another career for which they were qualified and might receive higher pay and status. One participant became a PSS after continuing in her previous career was no longer an option due to her mental illness, however none of the other participants mentioned being unable to work in other areas. Since the participants were not asked why they chose to be a Peer Support Specialist we can only speculate about their reasons

and this may be a good question for future study. Given the small number of participants the level of qualifications may not be representative of all PSS's. However, if it is a trend other questions this raises is how the PSS's coworkers viewed their credentials and whether these extra credentials make the job market for PSS's more competitive.

Inflexible Roles

There were certain feelings and experiences that some participants talked about that others did not, but because the questions were intended to be primarily open-ended and non-directive the researcher generally did not specifically ask other participants if they experienced similar things. One important example of this was Participant 3 who eloquently expressed her conflicted feelings about being expected to compartmentalize her life and aspects of herself. As a Peer Support Professional she was expected to only be a PSS and not utilize her RN skills or even mention this aspect of her life. Now when she works as an RN her supervisor expects that she not utilize her PSS skills or mention her personal experiences with mental illness. This could be a unique and painful conflict for Peer Support Professionals and/or people with mental illness as they are required to hide part of their identity, to deny a part of their self. This is reminiscent of the military's antiquated "don't ask, don't tell" policy. Like the aforementioned policy this enforced silence in the mental health field is also not sustainable and denies people with mental illness of their voice and their right to self-determination. It supports the illusion that there is a fundamental difference between "peers" and "professionals" and that Peer Support Professional is the only occupation that can contain both of these roles. Participant 6 similarly stated regarding peer status that, "I just personally hope that it's not limited to requiring the role of peer but that it can just be a social worker, a case manager that has had some of the same experiences." She hopes that peers can fill other roles and occupations in mental health rather

than only being utilized as PSS's. This role division may be due to stereotypes about people with mental illness and/or the phenomenon which Corrigan (2005) describes of mental health workers needing to believe that people with mental illness are fundamentally different from them in order to feel safe from it happening to them or someone they love. The existence of PSS's challenges this division which can create cognitive dissonance and fear or anger. This is something that should be further explored in future studies. A similar explanation for this role division is that due to their lowered expectations (one of the prevalent forms of discrimination coming from practitioners according to Corrigan) some people in the mental health field don't believe that people who are mentally ill can work and be professionals. This inflexibility of roles and categorizing people as either one thing or another could also be the reason that some participants described not being perceived as a person with mental illness or having their mental illness minimized by coworkers. By viewing PSS's as not truly mentally ill or somehow different from the clients that they serve they can maintain the division between "people with mental illness" and "professionals" in their mind. PSS's status as a professional makes it difficult for some people to believe that they also could be a person with serious mental illness, as those two things seem incompatible due to stigma and prevalent stereotypes.

Setting

Participant 6 described the most severe experiences of stigma and discrimination working as the only PSS in a hospital. She did not feel that she "integrated at all." Participant 3 worked in a hospital as an RN and stated that she "never really honestly could see a PSS starting at the hospital setting. " This suggests that hospitals may be one of the most difficult setting for PSS's to integrate into, perhaps as a result of the high acuity of their patients and/or the medical model or inherent hospital structure and culture. Other settings in which PSS's were more successfully

integrated were ACT teams, which have the expectation that there will be a PSS on every ACT team. That history of having peers and required PSS involvement may have made ACT teams a better work environment for PSS's. Other settings described, such as Community Support Programs and Clubhouses are generally more casual and much less hierarchical compared to hospital/medical settings, which could also be contributing factors. In the future hopefully PSS services will also be Medicaid reimbursable in inpatient settings, not just outpatient ones. This could incentivize hospitals to employ PSS's and lead to overall better integration as the inclusion of PSS's as hospital staff becomes the norm as it is currently for ACT teams.

Relationship Strengthening Techniques

Due to some of the barriers to integration that PSS's may encounter relationship strengthening techniques in the workplace are especially useful for PSS's. While the author wishes to make it clear that it is the workplace settings, supervisors, and coworkers of PSS's that bear the responsibility to change to facilitate integration, and not the PSS's themselves, the reality is that it is far more likely that PSS's will take action to facilitate their integration into the workplace. As a result, it is useful to share the strategies that the PSS's in this study utilized and found effective. The most common theme, cited by about half of the participants, was ingratiating themselves with their coworkers by working hard and taking on tasks that their coworkers disliked, perhaps even feeling the need to work harder than a non-peer mental health professional might be expected to. This could perhaps also be related to the high qualifications of the PSS's in this study. PSS's may feel pressure or the need to be a sort of "model minority" as a person with mental illness in a professional role. As happens with many minority groups the actions of one PSS may reflect on the entire PSS community or all PSS's as professionals, and PSS may very well be aware of this. With barriers to integration already prevalent, PSS's may

feel the need to work extra hard because their work is seen as representative of all people with mental illness. That is a great amount of pressure for a professional beginning in what can be a challenging and stressful field. A second theme was thanking coworkers and showing gratitude and appreciation. This is not necessarily unique to PSS's and may be employed by many people in the workplace. Future studies might compare workplace integration techniques utilized by peer and non-peer professionals to find how they differ and why.

Study Strengths and Limitations

This was an exploratory study designed to shed light on the factors that affect the successful integration of Peer Support Specialists into the Mental Health workplace. Peer Support Specialists were given the opportunity to describe their workplace experiences in their own words. The results cannot reliably be generalized to other settings due to the small sample size and geographic constraints of the sample to Minnesota. While the qualitative nature of the study made it possible to convey the exact words of participants, it also made interpretation subjective and misinterpretation possible. While some common themes were identified in this study, we cannot determine the cause of any correlation. There may be unidentified confounding factors. One potential confounding factor is the different types of workplaces in which the participants were employed.

Interviewing subjects individually with open ended questions made it more difficult to compare responses. In the future a focus group or group interview of PSS's might better facilitate a discussion of some of the themes identified in this study. As the interviews progressed some participants mentioned certain specific experiences, for example of stigma, which other participants might have also endorsed experiencing had they been asked directly. A focus group

or facilitated discussion among a group of PSS's might better refine themes and give participants the opportunity to either agree or disagree with other participant's opinions and define common experiences.

In spite of these limitations the findings can be used by mental health workers to better understand the experience of PSS's and by supervisors to make their supervision more helpful, relevant, and effective as well as to create an environment more conducive to the successful integration of PSS's. They cannot be used to draw conclusions but can be utilized to hypothesize, as well as empathize with the experience of being a Peer Support Specialist. The honest feedback of the participants of this study gives a glimpse into the experience of Peer Support Professionals in the Mental Health workplace and both their challenges and successes.

Implications for Social Work

The integration of Peer Support Professionals is important for social workers for two main reasons: 1) it is a social justice issue and 2) many social workers work in mental health and may work alongside Peer Support Professionals or even supervise them. The philosophy of Peer Support is very much in line with social work values as it is empowering, recovery-oriented, and it gives voice and agency to members of a vulnerable and oppressed population. Social workers should support the integration of Peer Support Specialists and should not be sources of the stigma and discrimination that some PSS's encounter. It is not enough for social workers to merely voice support for Peer Support Specialist, social workers must actively advocate for them in every mental health setting, must actively speak out about the stigma of mental illness, and must respect Peer Support Professionals as colleagues in the mental health field.

As coworkers of Peer Support Specialists social workers can and should provide a welcoming and inclusive environment. They can utilize PSS's in a productive way as resources, as cultural brokers or interpreters, as advocates for people with mental illness, and as sources of unique insight. All social workers can and should educate themselves about what a Peer Support Professional is, what they do, and how they can be best utilized. They should also be aware of the potential roles that people with mental illness may play beyond that of "peer," as a social worker, nurse, or other mental health professional. People with mental illness must not be confined to a "peer" role. Being peer-identified should be recognized and celebrated as a strength for people in any mental health related profession.

As supervisors of Peer Support Professionals social workers can utilize the information gleaned from this study to be better supervisors and better understand the pressures that PSS operate under and the stigma and prejudice they must contend with. Participants in this study clearly voiced that it is important that a supervisor be supportive, approachable, and "have their back" if they have any difficulties. Social workers as supervisors have the opportunity to help PSS's navigate some of the difficult and complicated boundary issues that may come up as well as some of the identity and role issues. As one of the participants expressed, having a good supervisor is crucial for success.

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Appendix A

Interview Questions

- What type of workplace do you (or did you) work in?
- What is (or was) your job title?
- How long have you worked there? (Or how long did you work there?)
- When was a peer support specialist position first created at your workplace (or former workplace)?
- Tell me about your work environment (or former work environment.)
- What type of relationship do you (or did you) have with your supervisor?
- What type of relationship do you (or did you) have with your coworkers?
- Do you feel that your position as both a peer and a professional affects (or affected) your relationship with your supervisor or coworkers in any way? If so, in what way?
- Did you have any difficulties or challenges integrating into your workplace when you first started working in your position?
- What, if anything, has helped you to feel welcomed, valued, and accepted at your workplace (or former workplace)?
- What, if anything, have you done that you feel strengthened your relationship with your coworkers?

-What advice would you have for another PSS starting at an agency similar to yours (or your former workplace)?

-Is there anything else you would like to share that you think is relevant that hasn't come up in our conversation?

Appendix B

Email to potential participants

Subject: Peer Support Specialist Study!

Peer Support Specialists:

I am conducting qualitative research on the integration of Peer Support Specialists into the workplace! I will be interviewing people who currently work, or formerly worked, as Peer Support Specialists. The interview will take approximately an hour and participants will be provided with the list of questions they will be asked before they consent to be interviewed. All identifying information will be removed and your responses will be presented anonymously in the final paper/presentation. In order to provide you, potential participants, with the context for this study I wish to disclose that I too am both a person with mental illness and a mental health professional. It is my hope that this knowledge will help participants feel more comfortable telling me about their experiences, knowing that I will understand what they are talking about and will “get it.”

There is no compensation provided for participating, but this is an opportunity for you to anonymously make your voice heard and provide feedback and advice that could be helpful to both agencies that are considering implementing a Peer Support Specialist and to other Peer Support Specialists who are beginning their first job! Please contact me by email or phone if you are interested in participating, or forward this email on to anyone else you think might be interested! Also please feel free to contact me if you have any questions about my research.

Thank you,

Maja Smedberg

Email: mbsmedberg@skate.edu

Phone: (612) 327-0578

Appendix C

Informed Consent Form for a Qualitative Research Project

Title of study: The Integration of Peer Support Specialists: A Qualitative Study

Principal investigator: Maja Smedberg

Institute: University of St. Thomas

Introduction:

I am Maja Smedberg, a social work student at the University of St. Thomas. I am doing qualitative research for my senior research project as a part of the Masters of Social Work program. Since you work (or worked) as a Peer Support Specialist (or an equivalent position), I would like to invite you to join this qualitative research study.

Background information:

The Peer Support Specialist (PSS) position has only recently been added to some agencies and programs in Minnesota. Beginning work as a Peer Support Specialist can be both challenging and rewarding for everyone involved. I would like to hear about your experience of integrating into a mental health workplace, as well as wisdom gained and any advice you have, for both agencies seeking to employ PSS's for the first time and PSS's who are beginning a new job.

Purpose of this research study

The purpose of this study is to determine what both the challenges, rewards, and effective strategies are for PSS's integrating into a mental health workplace, in their own words.

Procedures

In this study I will ask questions about your experiences working as a Peer Support Specialist (or equivalent position). This will likely take about 60 minutes. The interview will be recorded as a sound file for later transcription. After the conclusion of this study the recording will be deleted.

Possible risks or benefits

There are risks that this study presents. Talking about your experiences may raise uncomfortable or unpleasant emotions such as sadness, anger, or frustration. The interviewer (study author) will provide you with resources for support if needed. Another potential risk is that a former or current co-worker or employer will read this study and recognize your comments. This is a concern given the relatively small number of Peer Support Specialists in Minnesota and the presence of only one PSS in certain workplaces. All efforts will be made to conceal your identity and any identifying information will be removed from the interview transcript so the only way that anyone could ascertain (or suspect) that certain comments came from you is if they recognize your pattern of speech or if they have previously heard you make identical or similar comments. The benefits to your participation are that it may feel good to make your voice heard

and you may feel good about the possibility that sharing your experiences and feedback may improve the experiences of others in the future.

Right of refusal to participate and withdrawal

You have the right to end your interview and/or participation in the study at any time. You may refuse to participate without any loss of benefit which you are otherwise entitled to. You may also withdraw any time from the study without any adverse effect. You may also refuse to answer some or all the questions if you don't feel comfortable with those questions.

Confidentiality

The audio recording of your interview responses will be kept in a secure place and nobody except the principal investigator will have access to it. After the study is concluded and the interviews have been transcribed the recording will be destroyed. All identifying information (names, dates, and other specific information) will be deleted from the transcript and will not be used in the study. Your name and identity will also not be disclosed at any time.

Available Sources of Information

If you have any further questions you may contact the principal investigator, Maja Smedberg at (612) 327-0578 or mbsmedberg@skate.edu, or you may contact the head of the Research Committee for this project, Katharine Hill, at kmhill1@stthomas.edu.

1. AUTHORIZATION

I have read and understand this consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this form. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I further understand that nothing in this consent form is intended to replace any applicable Federal, state, or local laws.

Participant's Name (Printed or Typed):

Date:

Participant's Signature or thumb impression:

Date:

Principal Investigator's Signature:

Date:

Signature of Person Obtaining Consent:
Date:

Appendix D

Resources for Support

Walk-In Counseling Center

2421 Chicago Ave S.

Minneapolis, MN 55404

Main Phone:

612-870-0565

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Crisis Connection

MN Crisis Line: (612) 379-6363

Toll-free number: 1-866-379-6363