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ORIGINAL PAPER

Peer Support in Full-Service Partnerships: A Multiple Case Study Analysis

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Abstract Peer providers are integral to Full Service Partnerships (FSPs), which are team-based mental health service models. Peer providers use principles of recovery to engage clients, but FSPs can vary in their recovery orientation. Whether and how peer recovery orientation reflects the organizational environments of FSPs is unclear. This qualitative study explored peer provider attitudes towards recovery within the organizational contexts of FSPs where they are employed. Case study analysis was conducted on eight purposively sampled FSPs using qualitative interviews with peer providers and program directors. In two cases, peer recovery attitudes diverged from those of their organizational context. In these cases, peer providers were champions for recovery, and used practice-based strategies to promote client autonomy despite working in settings with lower recovery orientation. Peer providers could be uniquely positioned to promote client autonomy in settings where organizational factors limit consumer choice.

Keywords Full-Service Partnership · Peer Support · Recovery · Case Study Analysis

Introduction

Peer-based services are services provided to people with mental illness by individuals who have lived experience of mental illness and recovery (Davidson et al. 2006) and formal skills learned in training (SAMHSA-HRSA Center for Integrated Health Solutions 2016). The scope of these services includes encouragement of personal responsibility and self-determination, an emphasis on physical health and wellness, facilitation of engagement with health care, and recovery in general (Salzer et al. 2010). Recovery is the current perspective guiding the delivery of mental health services and approaches for people with mental illness (Ralph 2000). It is the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (Substance Abuse and Mental Health Services Administration 2014). Davidson and Roe (2007) describe recovery as clinical improvement in an individual's symptoms plus functioning and an individual's autonomy, or their right to self-determination and inclusion in life of a community of their own choosing.

The concept of recovery has its origins in the consumer movement (Ostrow and Adams 2012). A growing literature has reported that consumer led or, peer-based, services can lead to improvements in client outcomes, including reduced inpatient service use (Clarke et al. 2000; Min et al. 2007; Sledge et al. 2011) and improved engagement with treatment (Sells et al. 2006). Research has demonstrated that peer-based services have also led to benefits in hope, control, agency, and empowerment (Repper and Carter 2011), and also destigmatize mental illness and provide encouragement needed for consumers to reach their personal and clinical goals. Thus, the role of peer providers in mental

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health settings has been crafted and refined to embody the principles of the recovery model (Davidson et al. 2005).

Although the role of peer provider was created with this in mind, it is unclear whether peers are inherently recovery focused, or whether their attitudes towards recovery are a reflection of the cultures and policies of their organizational settings. This is an important consideration given that mental health programs can vary with respect to the amount of choice consumers are given in receiving services, particularly rules regarding sobriety, mandatory mental health treatment, and length of service receipt. Organizational culture is comprised of the norms and expectations regarding how people behave and how business is conducted in a given organization (Glisson and James 2002). It has been shown to affect individual provider attitudes, service quality, and consumer outcomes (Aarons and Sawitzky 2006). Given that there is variation in the implementation of recovery-oriented practices within mental health clinics (Slade et al. 2014), it is important to understand whether peer providers are inherently champions of client autonomy, self-direction, and ultimately recovery, or whether they only support client recovery and autonomy to the extent of their organizational home.

The Mental Health Services Act in California (Gilmer et al. 2013) provided an opportunity to understand peer provider attitudes toward recovery in the context of a large-scale implementation of full service partnerships (FSPs). FSPs combined supported housing with team-based treatment model and the expectation do "whatever it takes" to promote recovery (Gilmer et al. 2013). These programs assist with housing, employment, and education and provide mental health services along with financial and social supports for persons with mental health and co-occurring substance abuse disorders. Clients are recruited through outreach and referrals from psychiatric hospitals, emergency rooms, other mental health programs, county agencies, jails, shelters, rescue missions, and the street. Most FSPs deliver services to clients in real world settings: in their homes, workplaces, and other places in the community chosen by the client or deemed of therapeutic value by staff. Crisis intervention services are available 24 h a day, 7 days a week. FSPs were designed to support adults with serious mental illness across a range of service populations, which included transition aged youth, older adults, and formerly incarcerated individuals.

Although FSP guidelines prioritize the promotion of client autonomy, choice, and empowerment, the programs had considerable leeway to tailor services to their local contexts. An evaluation of FSPs (Gilmer et al. 2013) reported that many did not adhere to consumer choice in across all aspects of service delivery, suggesting that there was 'room for improvement' in the recovery-orientation of some FSPs in California. Given this variation in program implementation, we employed a case study approach to examine variation in the roles of peer providers or their attitudes toward recovery in their larger organizational context of specific FSPs. The goal of this study was to understand the role of peer providers in promoting client autonomy in programs that were intended to be recovery oriented. Specific research questions included: Is there variation in peer provider attitudes regarding client autonomy? To what extent do peer providers serve as champions of client autonomy? How do peer provider attitudes toward recovery and client autonomy fit into the larger organizational context in each program?

Methods

Sampling and Data Collection

The present study used a multiple case study approach (Yin 2003) to investigate peer services in eight FSP organizations. As part of a larger mixed-method implementation evaluation of FSPs throughout California (Gilmer et al. 2013), full-day site visits involving three evaluators were conducted at 20 FSP programs. These 20 sites were purposefully sampled from a statewide survey of all 93 FSPs using a maximum variation strategy (Palinkas et al. 2015) to provide in depth qualitative data on a geographic, political, and economic range of FSPs.

During site visits project evaluators conducted a total of 164 in-depth, semistructured interviews with program staff members including program directors, peer providers, clinicians, managers, and housing specialists among others. Each interview was recorded, transcribed verbatim, and entered into NVivo software (Fraser 2000) for analysis. Themes from the larger study are presented elsewhere (Gilmer et al. 2013). Of the 20 programs in the larger study, eight were purposively sampled for the present study based on their inclusion of peer providers as part of the staff interviewed during site visits. Six additional programs reported having peer providers that were unavailable for interviews on the day of the site visit. Interviews lasted approximately 40 min. In this study, we analyzed transcripts from both peer providers and program directors at each of the eight sites.

Data Analysis

Case study analysis (Patton 2005), which prioritizes depth over breadth, was conducted to understand peer attitudes toward recovery in their larger organizational context as described by program directors. Specifically, we analyzed the perspectives of peer providers and their program directors from each of the eight programs. We then compared

peer provider perspectives at each program to those of the program directors, conducting both within and across case analyses. This involved initially coding peer interview transcripts using a technique known as open coding that was influenced by sensitizing concepts (Charmaz 2006) from the recovery literature such as hope, client autonomy, and coercion.

Using coded material, peer perspectives on client autonomy along with illustrative quotes were then entered into a case summary matrix (Miles and Huberman 1994), with each program representing a case. Given that leadership has been shown to highly influence organization culture and climate (Aarons 2006), we also focused on program director attitudes toward recovery as a proxy for an organization's context in which peer providers were working. Program director transcripts were reviewed and a summary of their perspectives on hopefulness, client autonomy, and coercion was completed for each case.

Supporting data including specific quotes were entered in fields (columns) of the matrix. Within- and between-case comparisons using constant comparative methods (Strauss and Corbin 1994) were then conducted based on the completed case summary matrix that included peer provider and program director perspectives. The Institutional Review Board of [University of California, San Diego Human Research Protections Program] approved all study protocols. The authors declare no known conflicts of interest, and certify responsibility for this manuscript.

Results

The present analysis is based on transcripts of 16 interviews (n = 8 peer provider, n = 8 program directors) from eight FSPs throughout California. Individual interviews with peer providers revealed variation across FSP programs with respect to whether peer providers promote client autonomy and their specific techniques peers use to do so. Results also indicated that in some cases, peer perspectives on client autonomy and recovery were inconsistent with the larger organizational context, as described by their program directors. All names accompanying exemplary quotes are pseudonyms.

Promotion of Client Autonomy

Peer providers reported that they promoted client choice with respect to service use, medications use, and participation in addiction health services. Specifically, they did so using harm reduction techniques (Inciardi and Harrison 2000), their own personal style, and motivational techniques:

> I'll give you one of our hardest cases. So, her harm reduction is to come in one out of 5 days before 11 [a.m.] and be sober enough to walk, like, she can walk in here. And then, with that, she will get an hour and a half or longer shopping or going out to lunch, so we'll take her and she can go eat lunch with us. You know, we'll take her in the van. (Mike).

This peer provider described satisfaction with small victories that occur when using principles of harm reduction. In this example, Mike is promoting client autonomy by working with a client who is in recovery from addiction or alcoholism, rather than demanding that she be clean and sober. Peers also described using their personal style to ensure that clients are not coerced into treatment:

> He wanted to sign [the treatment plan], OK, but I wanted him to feel and be informed and I told him you don't have to sign this if you don't agree. We can work on this. If you don't agree with this we can talk with [name of supervising social worker] because she had made the treatment plan. We can talk with [supervising social worker] and we can work it out so that you're more comfortable with it. You don't have to sign. (Sam).

In this case, client autonomy was promoted by ensuring that a client is in agreement with the treatment plan before signing it. Peer providers also described using motivational techniques as an additional element of their personal style of promoting client autonomy. The following quote exemplifies a respondent's experience encouraging and motivating a client to stop engaging in behaviors that had previously resulted in incarceration.

> He says he's staying at the nephew's house, and then he'll tell you he's staying at his sister's house. And, he's actively using, and that's mainly his main pursuit right now. And, all I can do is point out the harm. He's already been to prison. He's not on parole anymore, so I just try to point out the behaviors that led him to go into prison initially and the behaviors he's engaging in now and try to point out the similarities. (Jean).

In this example, the peer provider recognized when a client was actively using drugs and persisted in drawing connections between the client's behaviors and negative consequences. Jean is also promoting client autonomy by 'pointing out the harm' of a client's behaviors rather than demanding that a client stop using drugs all together.

Hindrance of Client Autonomy

Some peer providers were less focused on promoting client autonomy. These peer providers described moments where they would decide what was in the client's best interest and act accordingly. In general, this was blanketed in the sentiment of caring: "They have these things that are necessary…I want to build a relationship. You're my client; I want to take care of you" (Karen). In one case, a peer provider described her reaction to a client who did not attend her orientation appointment for living in a transitional housing facility.

> I think [laughs] immatureness; I think also unfocused, irresponsible, too many things is going on with this person. And, I think that what I'm gonna do is probably making another appointment for her and try this again. I'll probably do it 'cause … I still want to help her get into this particular housing. … As far as getting a job, that's not gonna happen. She's unable to work. She doesn't have the self-motivation. (Karen).

This peer provider described her efforts to help a client secure housing, whether, whether the client was ready or not.

"Tipping point" in the Promotion of Client Autonomy

Peer providers described a tipping point, or a moment at which they insisted that a client make certain behavioral changes when they felt it suited their client's best interests, particularly if they felt client safety was at risk. This tipping point was a tension in balancing the promotion of client autonomy with the strong desire to help clients avoid making harmful choices. The following quote describes how a peer provider would intervene on behalf of clients to protect their best interests, when needed.

> I think when it comes to someone decompensating big time from substance use and being so deep in it that I don't think they're really gonna have the ability to say, like, I know what's best for me right now, or if someone is psychotic, you know, then I think it's our place 'cause they're harming themselves, and we do have the ability to step in and do something. (Alex).

This peer provider acknowledged the fine line between client autonomy and the point at which peers are unable to stand by and watch. Another occasion during which peer providers evoked the "tipping point" was when they want to ensure that their clients were receiving all of the service benefits they are eligible for, even if a client doesn't want to receive them.

> When clients don't want to go, I do all I can to encourage 'em. I mean, we need to talk about this. This is—sometimes they don't want to go to General Relief [a county financial assistance program]. That's money! You have to have that money. You have to have the food stamps. And when they don't want to go, they keep missing their appointments and keep missing their appointment, even though I'm there. I'm gonna take you there. You're gonna get there, OK? (Karen).

For several of these peer providers, the objective of their work with clients is to look out for them constantly, even if it means overstepping client autonomy.

Agency Policies Can Support or Hinder Peers' Promotion of Client Autonomy

Peer providers also described their approaches towards promoting client autonomy in the context of their agency's policies related to medication adherence and program participation. Many peer providers worked in agency settings that did not require medication adherence, and some described the challenges of working in such an environment:

> We offer medication and everybody sees the psychiatrist. Medication is a nonrequirement to stay in the program. So we have some clients who just say, "I don't need meds. I don't do meds." And we continue to help them daily in their more disorganized life than maybe if they were on meds. I don't know. I share what worked for me, with them. And then it's up to them and it's hard. (Tom).

In this case, the peer provider acknowledged the potential negative consequences that can occur when allowing clients to decide whether or not to take medication. While some peer providers described working within a setting that promoted client autonomy, several also described their program's policies as barriers to the promotion of client autonomy. Policies tended to be related to client participation in care planning and client involvement in decisions related to housing, such as involvement with board and care.

> There are some [individuals] where we just kind of know right off the bat that have to go to board and care, because of their history. Of being in and out, and not being able, not being med compliant, and the police are involved. (Val).

This quote suggests that a client's move into a board-and-care facility is a choice made by the service team, rather than the client.

Peer Perspectives in a Larger Organizational Context

Some peer providers described promoting client autonomy using harm reduction, motivational techniques, and their personal style, while others described elements of their practice that hindered client autonomy. A commonality was their acknowledgement that agency policies influence their abilities to promote client autonomy. To further contextualize the work environment in which peer providers operated, we compared peer opinions of client autonomy to those expressed by program directors. In six cases, peer provider attitudes and approaches toward promoting client autonomy aligned with that of his or her program directors while in two cases there were discrepancies. These findings are discussed below.

In four of six cases in which peer provider attitudes and approaches toward promoting client autonomy aligned with that of his or her program director, both the peer and program director expressed client-centered beliefs and described strategies and agency policies that promoted client autonomy. In these cases, program directors described their agency's pro-recovery context, which often offered structured staff training regarding the promotion of client autonomy.

> When we went through [structured training], it was seven sessions… it's not specifically about harm reduction, I would say, but it's a little bit more global than that, doing kind of a client-driven, client-focused kind of treatment plan and looking at a client based on strengths and needs, so really allowing the client to determine what their goals are and what's important for them, also obviously keeping safety in mind but really letting the client drive the car and knowing how to find those strengths and kind of foster that towards their own recovery. (Alex's program director).

In addition to having structured training, this director also described how a client's desire to be housed guided the process of obtaining client housing, whereas program staff members had very little authority. This director acknowledged how the care team accommodated clients who preferred to remain homeless:

> Certainly we don't have any leverage whatsoever around forcing anyone into any kind of housing. So, and there are plenty of people that don't really want any kind of housing. They'd rather just bounce around in hotels, and that's easier and better for them. And so, we have to deal with that, too, because, you know, to live in a permanent housing situation, they do have to kind of step it up sometimes around, like, substance abuse issues. (Alex's program director).

The peer provider also described client autonomy as an important part of the approach that guides client engagement, specifically decisions related to encouraging a client's community involvement. When asked how he encourages clients to integrate into the broader community and move on from their existing social networks, Alex responded:

> Yeah, that's tricky. I mean, because I think that you really—it's important to respect their culture, and a lot of times their culture is the people in the [name of neighborhood]. You know, I have a client who is 23. She hangs out down at [name of street] and drinks all day, and her friends are these guys in their 50s and 60s, and they're all alcoholics. But that's where she feels comfortable, and I don't feel like—I make suggestions, but that's her culture, so I think it is important to respect people's individual cultures, you know? (Alex).

In this case, the peer provider's approach extended beyond client autonomy to fully respecting people's cultures and personal preferences.

In two other cases, both the peer provider and the larger organizational context reflected limited client choice in some aspects of treatment. In one case, the program director described a process of placing clients in housing, implying that clients have a limited role in selecting the neighborhood where their housing will be located:

> If somebody wants to get an apartment and they're still using, then that's fine. We would still pursue trying to get them an apartment. We do have certain apartments that we've master leased…we try not to put clients in where we know that they're gonna fail. So if, we just know parts of town where there's a lot of gang activity, a lot of drug trafficking, and so we might not try to put them in that certain area, because we know they have a history there and we don't want to set them up to fail. (Val's program director).

The peer provider described a similar sentiment regarding a client's transition into housing and the team's process of preparing a client for such a change:

> Interviewer: The team makes a decision, then you visit the client, you say "We've got a place for you, you're gonna go here." And then you, do you help them move in?
> Val: We do, we do it all. We go get their stuff in storage, we go to their storage. If it's—wherever their stuff may be. Or if they don't have anything, we go and we'll—like today someone's gonna go buy some clothes for a client.

These quotes exemplify the care team's central role and the client's peripheral role in transitioning a client into a certain neighborhood and into housing.

In the two cases in which peer providers espoused attitudes toward client autonomy diverged from that of the program directors, the program directors described program policies and procedures that reflected lower prioritization of client autonomy, whereas the peer providers described using strategies that promote client autonomy. In these divergent cases, the program directors described how funding constraints shaped this organization's context, including agency policies and the availability of certain services.

> The problem that we run into with those types is the requirements of [the U.S. Department of Housing and Urban Development] of who qualifies as homelessness. They're very strict on that definition of homelessness. They have to be homeless at the time. Transitional housing doesn't count as homelessness. Living with a friend doesn't count as homelessness. I mean, they—I mean, sometimes we have to move our client. We'll call the [name of shelter]—the shelter and say, "Hey, can we have our client come stay there for a night, and will you guys write on a letterhead and confirm that so we can turn that in and show they're homeless," you know? (Jean's program director).
>
> Although the strict definition of what constitutes homelessness has clear implications for program enrollment, the following excerpt best summarizes the constraints set forth by funding agencies: "You know, the entities that oversee us, we have to kind of make them happy and do things how they think they should be done" (Jean's program director).

These program directors also described how agency procedures and funding constraints also shape decisions about housing and transitions out of the program.

> In the beginning we thought that [assertive community treatment] was a kind of a lifelong team program, community, family, but then realized for financial reasons that we're gonna need to graduate people so that we can serve more people because there's so many people that could benefit from the services. (Mike's program director).

Despite these organizational constraints, peer providers remained focused on client autonomy, despite institutional pressures to graduate clients before they are ready. These approaches included using motivational techniques, such as the peer provider reminding the client of negative consequences of certain behaviors, while still allowing clients to make their own decisions.

> They're adults, and it's their choice…our policy as an FSP is to meet 'em where they're at, and I usually address it through, the health aspect or interaction with medications. … I just, really try to keep it more focused on their mental health goals only, you know, if you're drinking and smoking weed all the time, you're gonna take away from the progress towards your mental health goals. … What's the benefit in you doing these things? (Jean).

In the end, these peer providers working in an organizational context that limited client choice still prioritized maintaining client choice by meeting clients "where they're at."

Discussion

We found that peer providers employed by FSPs throughout California described varying attitudes towards and strategies to promoting client autonomy. This was expected given the noted strengths of peers in promoting recovery in the literature (Davidson et al. 2006; Solomon 2004). From our results, we provide three main points of discussion.

First, we found that peer providers generally worked to promote client autonomy, but also reported having a 'tipping point' where they would overstep client autonomy in situations they felt were urgent. This was particularly true in situations of client safety and ensuring that clients were receiving all assistance they were eligible for. In two cases, peers described moments of overstepping client autonomy in less urgent situations. That there are moments where client autonomy raises important questions regarding specific roles of peers in these settings, and if and when it is appropriate for peer providers to overstep client autonomy.

Second, given that FSPs were developed specifically to promote client choice and autonomy, it is surprising that the organizational contexts, as described by the four program directors, created challenges in delivering fully recovery oriented care. In these cases, programmatic funding constraints were frequently cited as limiting the promotion of client autonomy. This was often because funding required some programs to terminate clients before the client was ready to move on. In two of these cases, the peer provider also described using practice techniques that did not fully promote client autonomy. It is not clear whether the organizational context resulted in the programs hiring of peer providers who were less client centered, or whether operating under this organizational environment compromised the peer provider's ability to promote client autonomy. Similarly, this organizational context's limited emphasis on client recovery could have been disempowering to the peer provider. Regardless, these two cases demonstrate

that it should not be presumed that all peer providers inherently promote client autonomy. Therefore, training in the promotion of client choice and autonomy should be part of the education of all peer providers. In this study we also found two cases where peer providers espoused client centered beliefs while their program directors described organizations that limit client choice. Unfortunately, these peer providers did not discuss their experiences working in these settings. Future research should explore programs where this discrepancy exists, to better understand the experiences of peer providers who remain recovery oriented despite organizational constraints.

Third, in two cases, peer providers described using practice strategies that promoted client autonomy that diverged from the perspectives of their program directors. In these cases, peer providers maintained their role as champions of client autonomy even when the larger organizational context was not entirely focused on this. Peers in these programs appeared to be more empowered than program directors to embrace recovery and promote client autonomy. Directors of these programs focused more on external constraints related to funding and resources that created challenges in delivering recovery oriented care. It is unclear how peer providers in these programs would respond if leaders were not supportive of recovery (rather than describing contextual constraints that created challenges in promoting client autonomy). Nonetheless, FSP settings were designed to promote client autonomy, and peer providers could be uniquely positioned to promote client autonomy using practice-based strategies such as motivational techniques, emphasizing client choice in treatment planning, and using principles of harm reduction. These strategies can be used even in settings with other organizational constraints (e.g., federally imposed definitions of homelessness or funding constraints that cause programs to graduate clients before they might be ready) that can create an environment that limits client choice in treatment.

Limitations

Our study has limitations that may affect its generalizability to the field. First, peer advocates at California FSPs might occupy unique positions that might not be typical in other mental health or human service settings. Therefore, the experiences and attitudes described here may not apply to other contexts. Likewise, the program directors of the FSPs featured in this paper might also differ from other mental health program directors in the field. A second limitation relates to the cross-sectional nature of our qualitative data. These data did not allow us to assess causal relationships between the influences of organizational contextual factors and the attitudes of peer providers or other FSP staff members. Third, demographic data were not collected under this study's research protocol therefore limiting the information we have about study participants. Further, social desirability could have influenced responses of study participants, since participants might have been reluctant to make statements that do not support recovery and client autonomy. Finally, the peer providers who were available on the day of the site visits might differ from other FSP peer providers in California. Despite potential selection bias, we contend that the eight organizations assessed in the present study clarified the practices related to client autonomy held by peer providers in their organizational contexts.

Conclusion and Next Steps

The general alignment of attitudes toward client autonomy held by peer providers and program directors suggests that recovery attitudes are influenced by agency policies and programmatic rules. Although an FSP's climate related to client autonomy is often institutionalized, this study shows that peer providers can serve as agents of client centeredness and recovery in organizational contexts that are less focused on these principles. Future studies might examine whether services provided by peers in organizations that are less focused on client autonomy and recovery are as effective as peer based services in organizations that have a greater emphasis on client choice.

Ongoing training of peer providers combined with promotion of the principles of recovery and client autonomy choice at the administrative level is needed to continue supporting their efforts to promote the autonomy of clients.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

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