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ORIGINAL PAPER

An Exploration of Factors that Effect the Implementation of Peer Support Services in Community Mental Health Settings

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Abstract This study explored the integration of peer services into community mental health settings through qualitative interviews with peer-providers and non-peer mental health workers. Results show peer job satisfaction was contingent upon role clarity, autonomy, and acceptance by non-peer coworkers. Mental health workers reported the need for organizational support for peer services and guidance about how to utilize peers, negotiate their professional boundaries and accommodate their mental health needs. Effective peer integration requires organizational readiness, staff preparation and clear policies and procedures. Consultation from consumer-based organizations, enhanced professional competencies, and professional development and career advancement opportunities for peers represent important resources.

Keywords Peer support · Implementation · Recovery · Workplace integration

Introduction

Peer support services are a key component of recovery-oriented mental health service systems (Cook 2011; Drake and Latimer 2012). Providers of peer support use their lived experiences of overcoming psychiatric distress to help others through a helping relationship based on credibility, mutuality, hope, and empowerment (Austin et al. 2014; Davidson et al. 2006; Moran et al. 2012; Russinova et al. 2011; Sells et al. 2006, 2008; Solomon 2004). Peers often serve as consumer advocates, engage in outreach services, and provide social, emotional and practical support to mental health consumers (Davidson et al. 2006; Gidugu et al. 2015; Salzer et al. 2010; Solomon 2004).

Peer-provided services are associated with a variety of positive outcomes including improvements in functioning, housing stability, quality of life, satisfaction with care and personal recovery while also reducing hospitalizations and use of crisis services (Clarke et al. 2000; Davidson et al. 2012; Felton et al. 1995; Lehman et al. 1997; Rowe et al. 2015; Sledge et al. 2011; Solomon and Draine 1995; Van Vugt et al. 2012). Peer services have also been found to increase recipients sense of autonomy, self-efficacy, belonging, and hopefulness, while decreasing psychiatric symptoms, self-stigma and substance abuse (Davidson et al. 2012; Rowe et al. 2007; Sledge et al. 2011; Solomon and Draine 1995; Tondora et al. 2010; Vayshenker et al. 2016). Peers also enhance the recovery attitudes and beliefs of their non-peer mental health co-workers (Walker and Bryant 2013). A number of studies and systemic reviews have found that the effectiveness of peer support to be equivalent to non-peer providers on a range of psychiatric outcomes (Chinman et al. 2000, 2014; Davidson et al. 2006; Fuhr et al. 2014; Lloyd-Evans et al. 2014; Pitt et al. 2013; Rivera et al. 2007; Rogers et al. 2009; Schmidt et al. 2008).

While the use of evidence-based practices (EBP's) in community mental health settings remains a top priority, multiple barriers to effective implementation of those practices exist at the system, organizational and practitioner levels (Aarons et al. 2011; Beidas et al. 2011; Damschroder and Hagedorn 2011; Isett et al. 2008; Greenhalgh et al. 2004; Rapp et al. 2010). The implementation of

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peer support services presents a specific set of challenges to organizations. This is because the practice of peer support requires the integration of a new professional into the organizational milieu with skills, perspectives and roles that disrupt and challenge the traditional way community mental health organizations interact, treat and respond to their clients. Recent research confirms that, indeed, agencies struggle to properly utilize peers. Peers experience low pay, stigma, alienation, unclear work roles and struggle with skill deficits, lack of training opportunities and burnout (Ahmed et al. 2015; Chinman et al. 2008; Garrison et al. 2010; Gates and Akabas 2007; Mancini and Lawson 2009; Moran et al. 2013; Salzer et al. 2009; Walker and Bryant 2013). Recent studies have identified role clarity, autonomy, respect and supervisor understanding of job role as important factors in peer job satisfaction (Cronise et al. 2016; Davis 2013; Kuhn et al. 2015). While these findings are important, studies that further explore factors and processes that impact the implementation of peer services into community mental health settings are needed.

This study responds to this need by exploring the benefits and challenges of integrating peer services into community mental health organizations through qualitative interviews with certified peer specialists and their non-peer colleagues. While several descriptive studies have examined the experiences of peers, few studies have also included the perspectives of non-peer colleagues and supervisors. The questions guiding this study are: (1) how do peers describe their experiences working in traditional mental heath agencies and what factors enhance and hinder their ability to integrate their practice in these settings? (2) how do non-peer mental health workers describe their experiences working with and supervising peers? and (3) what do each of these groups describe as the most important factors guiding the integration of peers into traditional mental health practice settings? Since peers often work with and are supervised by non-peer professionals, this study provides insights into the ways in which peers and their non-peer colleagues struggle to negotiate each other and what they need in order to work better together.

Methods

Study Design

The dual purpose of this study is to both examine the challenges and opportunities that peers and non-peer mental health workers experience when working together, and to help inform organizations and systems about how best to implement peer services more effectively from the perspectives of those on the front lines of practice. This study used a naturalistic, qualitative design relying on in-depth, semi-structured interviews with 23 certified peer specialists and 11 community mental health workers in the Midwest. Peers had current or past experience working in community mental health settings alongside non-peer colleagues. Non-peer mental health workers had experience working with peers or supervising them in these settings. At the time of the interview, the lead researcher obtained informed consent from participants. Interviews were audio-recorded and lasted from 45 min to one and a half hours. Each participant received $25 for participating in the study. The Institutional Review Board of the researcher's affiliated University granted permission for this study.

Recruitment

Peers were recruited from a statewide list of 56 certified peer specialists serving in 13 agencies in the Eastern region of a Midwestern state. The lead researcher worked closely with a consumer-run agency actively involved in the training and certification of peers to recruit participants into the study. A total of 23 peers agreed to participate for an acceptance rate of 41%. Peers worked in 10 of the 13 agencies that were a part of the original pool. All agencies provided community based mental health services to persons with psychiatric disorders. Services included supported housing, psychiatric rehabilitation, employment, case management, and outpatient psychiatric and substance abuse treatment. A convenience sample of 11 non-peer mental health workers were recruited from four community mental health centers serving persons with psychiatric disabilities. To be included in the study, workers must have had experience working directly with peers in either a co-worker or supervisory role. Three of the four agencies were the same agencies in which peers were recruited.

Data Collection

Peers and non-peer mental health workers were interviewed using separate guides. Both qualitative interview guides were based upon a review of the literature on peer-provided services and were reviewed by key informants within the consumer, survivor, ex-patient community for inclusive language, relevancy, respectfulness and specificity. The peer interview guide had 15 questions with multiple probes that explored peers' recovery experiences, service philosophies, and practice approaches. Several questions explored their experiences providing peer services at community mental health agencies and the most important factors that impacted the integration of their work in those settings. Some examples included: (1) what benefits and challenges have you encountered in your work as a peer in in the areas of organizational policies, non-consumer co-workers and supervisors, fellow peer specialists, and clients? (2) how do

non-consumer co-workers and supervisors see your role as a peer? and (3) what would help you do your job better?

The interview guide for non-peer professionals had 12 questions that explored their experiences working with peers at their agency, the services that peers provided, and the factors that facilitated and hindered the integration of peers in their agency and/or teams. Some examples of the questions included: (1) what benefits and challenges have you experienced from your work with peers? (2) how well are peers integrated into the organizational culture and workflow of your agency? (3) what are the factors that impact integration? and (4) what is needed to improve integration and help peers do their jobs better? Interviews with each sub-group revealed rich data regarding the factors that influenced integration of peers into community mental health settings. Participants talked fluently about their experiences, challenges and recommendations for improved peer integration.

Data Analysis

Transcripts were examined using thematic analysis methods (Boyatzis 1998). Approximately 70% of transcripts were independently coded by two researchers who then developed consensus on the initial codes and emerging themes within and across interviews (Saldana 2013). The lead researcher then independently coded the remaining transcripts. Memo notes were used to identify emerging themes, surprises, negative cases, and tensions as well as document analytic decisions and inform subsequent interviews (Charmaz 2006; Padgett 2008; Shenton 2004). Initial codes were refined and collapsed into broader categories that were compared and refined into general themes that were relevant within and across interviews (Boyatzis 1998; Saldana 2013). Trustworthiness was further established by interviewing until no new information emerged, repeated member checking with participants during the interview process for accuracy and the establishment of an audit trail that documented analytic decisions (Padgett 2008; Shenton 2004). Between-group analysis was conducted across peer and non-peer subgroups after initial analyses were completed within each of these groups. Comparisons, departures, tensions and surprises were noted and then further explored in the transcripts.

Participants

Table 1 provides demographic information for each of the subgroups in this study. The peer group was older, more diverse and acquired less education than the non-peer group. All peers had at least a high school diploma and most (87%) had some college experience. All non-peer mental health workers had Master's degrees in social work.

Table 1 Sociodemographic characteristics of peers and social workers

Sociodemographic factors	Peers (n = 23) %	Social workers (n = 11) %
Age range (years)		
26–30	0.0	63.64
31–40	8.70	9.10
41–50	43.48	27.27
51–60	21.74	0.0
61–70	26.09	0.0
Gender		
Female	56.52	100
Male	43.48	0.0
Ethnicity/Race		
African American	43.48	0.0
White, Non-Hispanic	56.52	90.91
Hispanic	0.0	9.10
Education		
Less than H.S	0.0	0.0
H.S. graduate	13.04	0.0
Some college	26.09	0.0
Associates degree	4.35	0.0
Bachelors degree	47.83	0.0
Masters degree	8.70	90.91
Doctorate	0.0	9.1

One also had a Ph.D. in Family Therapy. Peers averaged 3 years of peer experience and 3 years at their current agency. Mental health workers averaged 7 years of experience and 5 years at their current agency. Three quarters of the mental health workers were in supervisory positions.

Results

Peer-Described Factors Impacting Integration of Peer Services into Mental Health Settings

Analysis of peer interviews revealed approximately 40 integration codes. These codes were then organized into three broader themes that included: (1) job satisfaction, which refers to the level of clarity and autonomy peers have in their roles, responsibilities and expectations within mental health settings; (2) peer acceptance, indicating the level to which peers felt that they were an integral part of an organization or team; and (3) professionalization, which describes the professional enhancements peers identified as needing to advance their careers and roles within mental health organizations. Each theme was comprised of multiple subthemes that are described below.

Job Satisfaction

Clear Roles and Responsibilities

All peers identified the need for clarity in roles and responsibilities as the most important factor influencing the effective integration of peer services into mental health treatment teams and organizations. Lack of clarity was identified as contributing to blurred roles and unclear expectations leading to tension and dissatisfaction for peers. Peers reported that they were often hired into organizations with little information about what they would be doing. They also reported having their work roles change unexpectedly over the course of their employment. The lack of clear guidelines often led to confusion and at times resentment between peers and staff. For instance, one peer reported that her responsibilities suddenly shifted from providing Illness Management and Recovery (IMR) groups (a common peer service) to generalist case management. She stated, “I have never done [generalist case management] before, I don’t know how to do it. My role has always been to be the [peer] who does IMR. I don’t like feeling stupid in front of the clients. I didn’t know I had to be a generalist. I went and got my copy of my job description. There was nothing.” This lack of clarity was often the result of unclear policies and procedures, poor communication and a lack of staff training and consultation. Lack of clarity was a source of frustration for peers and non-peer staff that interfered with their ability to effectively work together.

Lack of role clarity also led to peers being misutilized by being placed in work roles that were not centered on using their lived experiences to help others in their recovery. Peers reported that they were often placed in roles and responsibilities above and beyond their expertise and qualifications such as doing intensive case management work even though they were paid well below their non-peer colleagues. They also reported being placed in roles below their qualification level such as serving as a van driver, filing paperwork, answering phones or performing data entry. The following quote highlights the frustration of one peer regarding the misutilization.

> We are trained to provide services to people who have similar health conditions to ours. We are trained to be supportive, we are trained in listening, we are trained in advocacy…we are trained to be mediators between consumers and the agencies that serve them. … [a peer] is not free, cheap subsidized labor…they [peers] have a specific level of expertise and they need to be working within that, drawing from that and using that as a gift to help other people.

The lack of clear guidelines regarding peer roles and responsibilities led to confusion within teams and organizations about what peers should be doing and how best to utilize peer providers. Peers identified the need for more intentional implementation strategies such as clear communication, specific guidelines and ongoing training and consultation for supervisors, peers and non-peer staff across the agency.

Autonomy

Peers identified autonomy as an important factor in job satisfaction. Autonomy included having the freedom to provide genuine peer services without micro-management, intimidation or interference by supervisors and non-peer staff. The work of peers often involves extensive outreach efforts in the field and the sharing of personal information in regard to one’s lived experience of psychiatric disability. Further, while serving in the capacity of a client advocate, peers must often challenge decisions, language, practices and policies of their team or organization. In order to practice effectively, peers must have adequate levels of autonomy in their position as indicated by the following quote.

> They [the team] understand that I’m giving the consumer perspective. It’s OK for me to say “Hey guys, this is burning me. Why are you saying this?” That I’m not constantly looking over my shoulder ‘cause I can’t stand micromanaging. They had enough confidence in me to say “OK, here’s what you’re supposed to be doing; go do it.”…I always feel comfortable if I want to talk about somethin’, just walking in the office and say “hey, I want your opinion on this.” And I also have my coworkers come to me and say “hey, let me run this by you and see what you think.”

As seen in this quote, peers who have adequate levels of autonomy in their position have clear roles and responsibilities, are trusted to do their job, and are supported by their team members who understand their role on the team. Peers that indicated that they did not have a high level of autonomy complained of being held to professional standards and guidelines that interfered with their ability to form genuine relationships with their clientele and of shifting expectations for their jobs. They also reported that they had to endure supervisors and co-workers who were untrusting of their abilities and unsupportive of their role on the team.

Peer Acceptance

Inclusion

Inclusion refers to peers’ sense of being a full member of the team or organization. Inclusion refers to how well peers ‘fit in’ with the team and how much they are included in team activities, events and conversations. The level of

inclusion reported by peers varied greatly across the interviews. Some peers reported that they were viewed as equal team members and had supportive relationships with their supervisors and teammates. For instance, one peer stated, “Team leader support is key” because the leader is going to give the cues to how you fit in with the team. It was just a given that I was an essential part of the team. I’ve never felt like I wasn’t.”

However, many peers also cited exclusion from team activities and functions. Peers noted that conversations occurring in break rooms or hallways would grow eerily silent when they appeared. They reported that they were often not included in management team or other decision-making bodies within the organization. They were also not included in social functions. As one peer reported, “We were not allowed to go to offsite parties. And that was really tough on me.” This peer noted that non-peer staff decided in a management team meeting, where peers were not present, that peers should not be allowed to go to off-site parties due to the fact that non-peer staff felt awkward having peers at these events. She reported that this decision was very hurtful to her, especially since she continued to get the all-staff invitation e-mails. She noted that upon further review the decision to exclude peers was rescinded by the administration.

Peer Respect

Peers also reported that the level of respect they received from their fellow team members was an important factor in how accepted they felt within the team. The advocacy functions of peers often placed them in an awkward position in relation to their other non-peer co-workers. As one peer stated, “How would you like it if one of your coworkers came up to you and said ‘you know, you shouldn’t be saying that because that’s very stigmatizing. You’re doing something wrong.’ We’re supposed to point out stuff like that. So we are in a very difficult position, a very odd position at the moment.” While many peers reported that they were respected members of their teams, several others reported situations were peers experienced being silenced and/or dismissed when attempting to advocate for clients or offer clinical suggestions. Peers stated that they received messages that their opinion was not as important as other non-peer staff. As one peer stated, “I think that the biggest challenge is that people think that we don’t know. I think people just think we lack the competency to be doing what we’re doing.” Some peers stated they were not given an opportunity to offer input in meetings and when they did it was either minimized or disregarded. A smaller handful of peers reported that they were openly disparaged in meetings and gossiped about by non-peer staff and supervisors.

Stigmatization

Stigmatization refers to peers experiencing unfair treatment due to being a person diagnosed with a psychiatric disability. Peers repeatedly reported that an important area needing to be addressed is the lack of organizational support, training and guidance on appropriate accommodations for peers. Many peers stated that they and their teams struggled to recognize and respond appropriately when they became symptomatic and needed time off. Peers reported that they were not treated fairly when they became symptomatic. For instance, when non-peer colleagues became sick or needed time off for personal or family reasons, peers felt those staff members were guided by clear policies and procedures and were treated with more respect and dignity than if peers became symptomatic due to their mental illness. Peers also stated that they were held to lower expectations on their performance due to their status as consumers. In some instances, peers stated that they hid symptoms from supervisors for fear of losing their job or out of embarrassment. One peer stated, “I suffer from depression but I’ve been, in remission or asymptomatic for years now, but it hasn’t always been the case since I’ve been on the job. There was at least one episode of depression that was significant and I felt I had to hide it, and I guess I did.”

Several peers also identified times when normal variation in behaviors such as being grumpy, questioning, sad, or overly joyful were viewed through a symptom lens and labeled as depression, mania, paranoia or agitation. Peers were unanimous in the need for agencies to have a clear accommodation plan and advocated for open communication about symptoms between the peers and their direct supervisor and, if appropriate, team members.

Professionalization

Ongoing Professional Development

Peers clearly stated that they required ongoing professional development opportunities as a means to enhance their integration into mental health agencies. Peers complained that after taking a 5-day training, they received no other opportunities to further develop their skills or advance their careers. Most peers that participated in this study noted that they needed opportunities for further certification, credentialing or licensing. They also stated that they required continuing education in several topics including clinical diagnosis, motivational interviewing, trauma-informed care, suicide risk assessment and prevention and resource management (case management). The following quote highlights the needs for further training and professional development.

> I'll tell you something else about peer support. You get certified by DMH. You go take this week training. You're certified. That's it. That's all. [T]here's no accountability and I believe in accountability. And, you don't have to take any other trainings so it's like you're out there.

As seen in this quote, peers frequently reported that they, like other helping professions, should be mandated to receive continuing education in order to keep skills current and peer workers accountable to their profession. Another rationale noted was the need for career advancement in order to receive better pay and a "career ladder" such as steps or ranks that reflect skill level or experience. Peers noted that these methods would allow them greater legitimacy and bargaining power within traditional mental health organizations.

Enhanced Professional Standards

Peers also stated the need for enhanced professional standards in order to both advance the peer profession and to provide peers with clearer practice guidelines. Peers were very vocal for the need for clearer and more detailed ethical standards, particularly in the area of professional boundaries. As an example, a peer stated, "[a client] called me at midnight. And she's the reason I stopped giving my cell phone out…When people go in the hospital…they expect you to visit them. Like all the time. I want to be treated like there are boundaries, just like a therapist has boundaries." While peers desired clearer ethical boundaries, they also complained that they were held to the ethical standards of non-peer professions such as social work that eschew the sharing of personal information and close personal relationships that have come to define peer work, thus interfering with their ability to perform their duties effectively.

Peers also stated the need for more accountability standards for peers in order to have greater quality control over who is allowed to practice in the profession as indicated in the following quote.

> I think, too, we have to make sure that we hire peers that are ready, professional, and have time in recovery…because I think a lot of times what happens is that agencies they'll get somebody that just because they want to get peers, just because they need a peer there. And so we had a peer that was working and all he did was drive a van. We had another young lady and she just made sure people signed in. I think that's a misuse of the skills if they can do better.

As the above quote suggests, peers were concerned about the level of variation that existed in the peer field. Peers were strongly concerned about the level of quality in the profession and advocated for more quality control and accountability. Furthermore, peers served a variety of functions and roles and possessed a variety of educational backgrounds, skill levels and experiences. Despite this variation, there were limited opportunities for professional advancement. For instance, a peer with a high school diploma driving a van or performing data entry, was paid the same as a peer with a bachelor's degree providing case management services at the agency.

Lastly, most peers stated the need for enhanced peer supervision and support networks in order to provide mentorship and reduce the sense of isolation and alienation that can come from being the only peer at an agency or on a team. They expressed frustration that their direct supervisor was most often not a peer, but rather a non-peer professional who did not understand the nature of their roles and responsibilities and, at times, did not support their work. Peers stated the need for outside peer mentors and supervisors as well as networks of peers that they could access for support, information and guidance.

Social Worker-Described Factors Impacting Integration of Peer Services into Mental Health Settings

Approximately 23 codes emerged from the analysis of transcripts from 11 non-peer mental health workers. These codes were then organized into two broader themes that included: (1) Fidelity, which refers to the need for a clear set of policies and procedures guiding peer services; and (2) organizational culture and support, which refers to the need for implementation strategies that include leadership support, team-building, quality supervision and ongoing training in the use of peer services. Each of these themes was comprised of subthemes, which will be described in the sections that follow.

Fidelity

Role Clarity

Like peers, non-peer mental health workers identified role clarity as the number one issue impacting the effective integration of peers into mental health settings. They struggled to understand peers' specific roles and how best to utilize them on their teams. Many reported that they had little or no information about the role of peers and what services peers were supposed to provide. As one non-peer mental health worker stated, "The struggle has been "I don't know how best to use that position" or "we're just so busy, I need them to do this, even though I know it's off-model"… And I think there can be that tendency to maybe do it more with Peer Specialists, because with less understanding about how to best utilize their peer specialty." The lack of role

clarity led to abuse of peers by putting them in positions that were above or below their experience level (i.e. misutilization). For instance, under-resourced teams relied on peers to provide services better reserved for persons with training in case management. The lack of clear organizational policies contributed to this misutilization as seen in this quote.

> I think it would be great to have some very clear expectations for what the peer is expected to do… and what their role is, and what the ethical boundaries are. Like very clear, written out, here's what we expect. That would help, I think, team leaders know what things to enforce, and what things they can't. I think it would help Peers have more comfort level in what they're doing every day. And I think it would also help other colleagues have a clear understanding, like, "OK, this is what they're supposed to be doing."

All non-peer mental health workers noted the importance of communication and guidelines for peer roles and expectations. Most noted that they were told that they had to hire a peer specialists and were given no information about what a peer was supposed to do on their team, nor did they receive any training or consultation about how best to implement peers.

Blurred Professional Boundaries and Expectations

Similarly, all non-peer mental health workers struggled to understand and manage the professional boundaries and ethical expectations of peer providers. Examples given included peers giving out personal cell phone numbers and going out together to lunch, church or 12 step meetings with the people they served. Supervisors typically held peers to the ethical standards of their own profession (i.e. social work), but recognized that these standards were inadequate to support the needs and experiences of peer providers. For example, most social workers struggled to understand the differing level of relationships between peers and their 'clients' which is more personal due to the nature of their shared lived experiences as indicated by this supervisor when she stated, "she gives her cell phone out so clients just call her late at night" and say, "I'm going to talk to her." Kind of weird…I'm kind of uncomfortable with that. Should I be? I don't know. I don't know what the boundaries are. And the agency has neglected to address that.

As the above quote illustrates, the personalized role of the peer in their work with others can lead to confusing and ambiguous professional boundaries requiring specialized supervision and support. Non-peer supervisors were not given guidance on how to best supervise or manage peer specialists. Despite there being a code of ethics designed for peer specialists, this code was not shared with the team, nor were any training experiences provided to teams (including peers) to outline the specific professional ethical boundaries that guide peer work. Non of the peers or non-peer workers interviewed was aware that a professional code of conduct for peers even existed.

Organizational Culture and Support

Teamwork

Non-peer mental health workers identified teamwork as a key element to effective peer integration. Teamwork refers to the level of camaraderie, mutuality and respect teams and supervisors showed peers. This was similar to the inclusion and respect codes under the theme of peer acceptance described in peer interviews. In the interviews with non-peer mental health workers, these concepts were not distinct enough to split into their own separate categories so they were combined into the teamwork subtheme. The level to which teams included peers as full members varied across the social work interviews. For instance, some teams fully accepted peers as members as illustrated by this supervisor when she stated, "We all get along, we're all like a big family. The peer before came to my wedding. I mean we share in each other's lives. It's more than just we're coworkers. We all really like each other. We hang out outside of work. [The current peer] on my team came to my baby shower."

However, some struggled to include peers as full members of the team or organization. For instance, peers were often not included in some team events. One supervisor, commenting on a situation that was brought up in another peer interview, stated, [W]e *didn't* invite [the peers] to the Christmas party the first year. And that was really hurtful… And I felt pretty mad about that. It didn't seem fair to me. Just setting up these boundaries. What are the boundaries? What should they be? If there's drinking should we invite them? I don't know sometimes those lines get blurry." Non-peer mental health workers genuinely struggled on how best to involve peers in team activities and events. Some of these concerns had to do with staff not wanting to cause a setback in peers' recovery. It should be noted that peers never voiced a concern over whether a team activity might cause a relapse. The concerns of peers centered on the hurt that they experienced being excluded from the activity. Despite this, concerns of non-peer staff did result in some creative solutions to issues that may have been beneficial for the team overall as evidenced in the following quote about whether or not to invite a peer to happy hour.

> Sometimes there's weird things we have to think about that we might not have had to think about before. Like for instance. If we're having a team

> happy hour……are we going to go out and have happy hour and everybody drink beers when we have a person who is… …in significant recovery, trying to not use drugs and alcohol? That feels weird. It feels weird to have a team happy hour. She's not going to go to that, because…she's not going to. But then that's kind of excluding her from…team building or team social activities. Which feels weird, so we've been trying to think of some creative ways to get around that.

Teamwork means more than just getting along and caring for each other. It also requires team members to respect peers as colleagues that have important contributions to make to the team, which can often involve challenging other team members on their language choices and clinical decisions. Respect for peer work was associated with clear roles, peer autonomy and inclusivity. However, social workers also reported that their teams struggled with this aspect of peer services as one non-peer mental health worker stated, "A part of your job here is to call us out when we're not being sensitive…when we're falling into stereotyping…And we're telling you that's part of your job, but then we get sort of defensive when you actually do it." This quote coincides with two integration elements that peers identified as being important: peer respect and autonomy. Although the role of the peer was known, the fact that a peer would challenge the language choices or decision making of non-peer colleagues was not always accepted. This places peers in very awkward position and can expose them to intimidation or harassment, especially when they do not have adequate levels of supervision or support. It can also interfere with their ability to carry out their duties freely without interference or micromanaging.

Peers were also positioned as second-class professionals as illustrated by this non peer mental health worker when she said, "In some teams, there's a little bit of like 'You're a real part of the team and you have a role, but it is a *less than* role.' So you can have your *say*…but then the real professionals will make the decision…And be kind of blown off…kind of feeling like patted on the head a little bit." As the quote suggests, peers' were often disregarded or minimized. This view was also supported by peers who stated they were often silenced or their perspective minimized in meetings with non-peer colleagues.

Accommodations

Supervisors and team members struggled to come up with an action plan for peers who became symptomatic and were often unaware of what accommodations were available at their agency. Despite these struggles, several social workers indicated that they were able to come to a satisfactory arrangement with their peers.

> I realized I should have done it at the beginning, but no one told me I should have, but really made an agreement. Like what do you *want* me to do? "How do you want me to handle this? What would be helpful to you in those situations?" And [my peer] [said] "Well, you should know what my [Wellness Recovery Action Plan] WRAP plan is!" "Here's how I am when I'm not doing well" "Tell me if you see these things." Here's what I need from you, in these situations. This doesn't help. This does"….and it worked.

Non-peer supervisors repeatedly stated that they had little guidance from human resources or their agencies upper management regarding what to do when peers needed time off due to their mental illness. This lack of knowledge not only places peers in dangerous situations where they could be treated unfairly, but also opens agencies up to potential litigation and other sanctions. Clear communication and planning was identified as an important strategy to develop effective accommodations and vital to avoiding negative consequences for peers including discrimination, job loss, humiliation and a loss of trust with co-workers.

Strategic Implementation

Lastly, social workers acknowledge that support from the top of the organization was an important element in the effective integration of peer provided services. Administrative support is defined as the intentional implementation of peer services that includes: (1) the support and full endorsement of the concept and philosophy of peer services; (2) a clear and coherent set of policies and procedures governing the use of peers; (3) the inclusion of peers in the decision making of the agency and (4) the provision of longitudinal training and consultation to teams. Several non-peer mental health workers noted that policies and procedures governing peer services were poorly communication or were not adequately put in place.

> Organizationally, when I've gone for help around peers it's "we're doing it because we have to." I mean that's like even what I've heard – that exact sentence. And so I think there's this lack of respect, and lack of trust, that they are clinicians. That they can make a difference. I think it's like, "Oh, good! They'll be *friends*. And that's nice. That helps people recover. *Friends*. OK. Good. And so if they're sick and they stay home it doesn't really matter. They're friends or whatever." It's weird. It's disappointing.

As the above quote indicates, the effective implementation of peer services is a complex undertaking requiring

philosophical as well as instrumental support from administration. Not providing this support can result in confusion, frustration and ineffective service provision.

Discussion

The findings of this study support others that found that peers thrived in organizational environments that provided them with clear roles and expectations, professional autonomy, acceptance, and respect (Cronise et al. 2016; Davis 2013; Kuhn et al. 2015; Moran et al. 2013; Myrick and del Vecchio 2016). As has also been found elsewhere, peers and mental health workers routinely reported confusion regarding expectations for peer work roles, professional boundaries and proper guidelines for accommodating peers' mental health needs (Cronise et al. 2016; Garrison et al. 2010; Moran et al. 2013). Peers also routinely experienced various forms of stigmatization within their organizations (Mancini and Lawson 2009). Peers were not afforded the same privileges as their non-peer colleagues and were viewed as a kind of hybridized 'other' neither full staff member, nor client. This made the peer reality confusing not only for peers, but for their non-peer coworkers as well. Results support other recent findings that found that a lack of readiness on the part of peer and non-peer staff might play a large role in these experiences (Garrison et al. 2010; Hamilton et al. 2015).

The contributions of this study include the exploration of the factors that impact implementation of peer services from both peers and their non-peer colleagues. This study found that the very things that make peers unique and effective may also contribute to the confusion and apprehension they experience working within traditional mental health settings. For instance, the nature of the peer relationship with the people they serve, predicated on sharing ones own recovery narrative, is inherently personal requiring professional boundaries that are more fluid. This opens the potential not only for deeply therapeutic alliances, but also for an increased potential for burnout, dual relationships and relapse. Peers require clear professional boundaries and reasonable accommodations so that they can maintain their wellbeing and continue to be effective and responsible to their co-workers. Furthermore, the ability of peers to recognize and disrupt practices in their organizations that are stigmatizing make them excellent advocates and change agents. When colleagues misunderstand this role, peers face being excluded, disrespected and silenced.

These inherent tensions place a significant responsibility on mental health organizations, professional preparation programs, consumer-operated service programs and state mental health departments to adequately prepare their staff to effectively implement peer-services (Hamilton et al. 2015). In order for organizations to effectively integrate any new practice into their day-to-day operations they must have the proper level of technical support at the system level including policies, training, standards of care, and billing requirements (Beidas et al. 2011; Damschroder and Hagedorn 2011; Garrison et al. 2010; Greenhalgh et al. 2004; Hamilton et al. 2015; Isett et al. 2008; Mancini and Miner 2013). An outside peer organization or ombudsman could help provide technical consultation and peer supervision to organizations. (Garrison et al. 2010).

The use of peers must align with the shared values and readiness of the organization and its practitioners (Aarons et al. 2011; Greenhalgh et al. 2004; Damschroder and Hagedorn 2011; Garrison et al. 2010; Glisson et al. 2008; Hamilton et al. 2015; Mancini and Miner 2013). Organizations must have highly developed policies that include clear guidelines regarding work roles, expectations, paperwork, confidentiality, professional boundaries and accommodations (Ahmed et al. 2015; Davidson et al. 2012). Peers must be held to the ethical codes of their own profession and not to those of other professions. Peer representation on organizational decision making bodies is important in order that peers have a voice in how they are used across the agency.

Practitioners must be prepared to support peer work. Professional education programs can provide adequate preparation of their students in peer work through readings, guest lectures and field experiences. Local peer organizations can partner with these programs to provide these experiences. At the community mental health organizational level, a group of well-trained and supportive champions, particularly administrators and team leaders, is vital in implementing and sustaining any best practice across an organization (Aarons et al. 2011; Beidas et al. 2011; Damschroder and Hagedorn 2011; Davis 2013; Hamilton et al. 2015; Kuhn et al. 2015; Manuel et al. 2009; Mancini and Miner 2013; Rapp et al. 2010). This preparation involves adequate orientation and training of staff on the history, codes of ethics, effectiveness, and roles of peers. Again, peer organizations can collaborate with state, county and local community mental health organizations to assist in the provision of this training. Finally, the varied roles and responsibilities of peers requires the continued development of competencies, certification requirements and professional development opportunities to better prepare peer providers to practice effectively and provide opportunities to enhance their skills and advance their careers (Myrick and del Vecchio 2016). This increased professionalization can contribute to enhancing role clarity, autonomy and pay scales that have been found to be crucial to peer job satisfaction (Cronise et al. 2016; Myrick and del Vecchio 2016).

To summarize, this study contributes to the literature by more explicitly identifying the system, organizational and professional factors that contribute to the effective

implementation of peer services within community-based mental health organizations. Effective implementation requires an extensive level of organizational readiness. This readiness includes proper resource allocation, clear policies and procedures, staff preparation, organizational dedication, and ongoing technical support. Systems and organizations must be prepared to invest these resources in order to maximize the beneficial effects of this important service. Understanding the factors that impact the integration of peers into traditional mental health organizations is just beginning. Future research must continue to focus on understanding the organizational contexts that help peers thrive in order that they may continue to help transform mental health services in the twenty-first century.

Limitations

The small sample used in this study was gathered using purposive sampling methods. As a result, this sample does not represent the full range of views regarding this topic. While several methods were used to establish credibility and trustworthiness, the interpretation of interview transcripts may have been influenced by biases held by the researcher. Likewise, various forms of response bias may have influenced participant's responses as well.

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