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Mental Health Peer Career Pathways and Impact: The Results of Lived Experience on Recovery

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Abstract

Peer support professionals bring lived experience to the recovery process, have training and certification as professionals, and are increasingly integrated disciplines in mental health and substance use services. Outcomes for clients of peer services include decreased hospitalization, decreased substance use, improved housing stability, and improved engagement in treatment. The scope of peer support work, particularly in providing services for individuals with mental health and substance use, or co-occurring needs, is still evolving. While the outcomes for individuals served are compelling, less is understood of the effect of peer services on non-peer colleagues and the peer professionals themselves. A qualitative narrative interview analysis was performed with 15 peer support professionals providing co-occurring services as either part of an interprofessional team or as part of peer-run services. Six content categories were identified, with most common content areas being the sense of relatability, experience with the system of care, individual and societal impact, and impact on one's own recovery. Insights into policies and career pathways for peers over the last five years were noted. Implications for policy and practice in the coming years to grow peer services are discussed.

Keywords: Peer Support; Recovery; Lived Experience; Policy; Qualitative Research; Participatory Action Research

Abbreviations: RCT: Randomized Control Trial; DUS: Drug Use Severity; HSIRB: Human Subjects Institutional Review Board.

Introduction

Peer professionals are individuals that have personally experienced life with a serious mental illness or substance use disorder, have successfully navigated the recovery process, and have received specialized training and certification to assist other individuals living with mental illness and substance use, or co-occurring disorders. Having participated in the behavioral health system as both recipients and service providers, peer support providers offer a unique perspective of lived experience. Peer professionals are unique relative to routinely disclosing their first person experience lived experience in assisting individuals in navigating complex service systems, living in poverty, and dealing with discrimination [1,2]. These individuals may be distinctively qualified to serve as a bridge between service recipients and behavioral health clinicians, helping consumers navigate systems, benefit from mutuality in their services, and discover recovery pathways through the help of a peer provider guide.

History and Role Development of Peer Professionals

While peer services within mental health and substance use systems for at least the last 300 years, and in mutual aid/

self-help groups for over 100 years [3], the development of peer support as a formalized professional group within North America began during the 1990s. This was in part a response to the Mad Pride, civil rights and anti-psychiatry movements, which sought to expose the coercive or criminalized practices of mainstream behavioral health care, and to envision alternative groups of professionals [4-8]. In an effort to establish an alternative to the pervasive paternalistic dynamic present in behavioral healthcare, the concept of formalized peer support was born. Services operated for and by people with behavioral health needs now outnumber traditional services that do not incorporate the peer experience [9]. In Davidson L, et al. [10], the first sentinel review of the evidence surrounding peer support, the authors describe three types of peer support: informal supports, peer-run programs and peers as providers of services with other professionals. Although there is compelling evidence of the impact of all three, this study focuses on the second two categories alone, or professional peer support providers. Peer providers bring build-in reciprocity to services and an opportunity for growth towards recovery through shared experience [11].

Pilots of the use of peer professionals began as early as 1986 [12]. In 1999, peer support services became a Medicaid fundable service in the State of Georgia [13]. In 2007 the Center for Medicare & Medicaid Services began providing reimbursement for peer support services nationally, which offered peer support providers increased employment and engagement opportunities within behavioral health systems [14]. The services provided by peer providers, defined in 2007 as a Medicaid billable service, include requirements that peers a) are supervised by a mental health professional, b) care-coordinate with an individualized plan of service, and c) train and pursue credentialing as peer providers [15]. Despite this codification of the peer professional role, peer professionals continue to experience exclusion and micro-aggressions by non-peer colleagues [16], which highlight the ongoing need to reduce stigma and to advocate for civil rights of people with behavioral health needs.

Outcomes of Peer Services for Individuals Served

Recent reviews of peer professionals in mental health services specifically speak to peer professionals in case management, ambulatory, and inpatient settings, both alongside other non-peer professionals as well as in peer-run services [17]. In Randomized Control Trial (RCTs) in mental health services, there is evidence of increased community tenure [18], decreased rehospitalization [19-21], and a reduction of days used in hospital associated with peer support services.

Increased scores on empowerment measures [22,23] speaks to the role of peer support as raising awareness of advocacy and efficacy among service recipients. Davidson L, et al. [10] also demonstrated increased self-esteem on structured measures associated with peer services, addressing the distinct outcomes of mutuality and reciprocity in peer services. Solomon P [2], Nelson G, et al. [24,25], Ochocka J, et al. [26], and Forchuk C, et al. [20] each found improvements in community integration or social supports with mental health peer services. This may be related to greater feelings of acceptance with peer services are integrated [27].

Outcomes of peer services for co-occurring mental health and substance use disorders have been studied less frequently. In an early study, a RCT found decreased hospital admissions and fewer days in hospital in the peer services group [28]. Increased community tenure and decreased overall rates of hospitalization were outcomes for individuals with co-occurring needs with peer services [29,30]. Klein AR, et al. [29] found decreases in the Drug Use Severity (DUS) scores with co-occurring peer services.

In qualitative studies of peer services for mental health clients, peers offered positive relationships, a sense of belongingness, and increased connection to the mental health system [10,31-33]. Peer services are both a political movement of self-determination and community integration, and an effective treatment modality. Key components of effective mental health peer services in qualitative studies include a sense of mutuality, limit-setting by the peer, and a difficult to define phenomena of normalization defined in one study as 'knowing you are not crazy' [34]. Additionally, service recipients often report that peer support providers are more approachable and relatable than other behavioral health professionals [35]. The qualitative effects of peer services as part of co-occurring teams are not as well known. This speaks to the traditional silos that have been created by mental health and substance abuse services; they are often offered by different agencies and providers [36], which may be replicated in the peer community; artificially separating peers with mental health recovery journeys from peers with substance use recovery journeys.

Outcomes of Peer Services on Peer Providers

In a previous analysis of the experiences of peer support providers, participants reported satisfaction with their work supporting others through the recovery process, citing greater confidence and improved perceptions of their own recovery [37]. Bracke P, et al. [38] showed that providing peer support has a positive impact on self-esteem. In interviews of peer professionals, the structure, income, and role of peer a professional were all valuable [39,40]. Salzer MS, et al. [41]

also noted continued skill development as helpful for the peer professionals' own recovery journal. There were no studies found that spoke to the impact of being a co-occurring peer professional on those peers themselves, a gap this study hoped to begin to fill.

The positive impact of peer support in mental health and co-occurring settings on outcomes including hospitalization empowerment, and social engagement is compelling. The research surrounding the experience of peer support providers in mental health settings themselves is more limited; this is even more the case when looking at co-occurring peer services. It is this gap in understanding how co-occurring peer providers may differ qualitatively from mental health peer providers, and to add to the research on the impact on peer providers themselves. Co-occurring peer providers need to bridge not only two complex and oft siloed systems of care, but navigate their own recovery from co-occurring disorders while in a professional role. The objective of this qualitative study was to gather narratives from peer support providers providing co-occurring services and observe trends detailing participant experiences working in this role. It is the aim to add to the literature on the role of co-occurring peers on the peers themselves as well as their perception of their role with colleagues, clients, and the system of care as a whole.

This study addressed the following questions: How does serving in this role impact peer professionals themselves? Individuals served? Non-peer colleagues? On the system of care itself? It was our hope to gain further insight into not just the impact on individuals served, but also the impact of the field on peer workers and their impact on the field of mental health, substance use, and behavioral health as a whole.

Methods

In order to obtain information about the impact that peers have on different aspects of the behavioral health system of care, and influence that system of care has on the peer workforce, the obvious informants are peer professionals themselves. Narrative interviews are a useful tool in this type of inquiry as a way to engage peer support providers not only as research subjects, but as active participants in the development of the science related to peers in a way that challenges the traditional frameworks of researcher and subject [42-44]. Specifically, individuals who have been diagnosed with a serious mental illness and/or substance use disorders are often disempowered, and face their identity becoming their diagnosis [45,46]. The role of transitioning from peer client to peer provider means both maintaining that identity, and simultaneously shifting it to becoming a provider [47,48]. Qualitative methods allow for discovery of more subtle factors in play at the individual peer professional level [49]. In this way, it is useful to understand the perceptions of peer professionals of their own work, and their work vis-à-vis clients, colleagues, and systems of care.

As a result, the method selected was semi-structured narrative interviews with peer support providers in a region of a Midwest state over an eight-month period in 2018-19. Following approval by the Human Subjects Institutional Review Board (HSIRB), advertisements for interviews were posted in hard copy and digitally with local behavioral health organizations, including peer-run and other organizations, inviting peers to call if interested. Interviews were scheduled for one hour, at a time and place of participant's choosing or available by phone if preferred. Interviews commenced following the securing of informed consent and explanation of study, including risks and benefits.

Interviews were semi-structured, with questions listed in Table 1. The questions provided only a framework for the ensuing discussion, rather than a strict parameter, and conversations often extended well-beyond the nature of the original question. Interviews were recorded on a mobile device, and later transcribed with back-up notes taken during the interview itself, after which the recording was deleted. Transcripts, as well as consent forms and interview notes, were tagged with a unique identifier. At the end of each interview, peer support providers were asked to identify others that might be interested in being interviewed, using a snowball sampling method.

Question number	Question content
1	Please give me an idea of what it was like to become a peer support. What were some of your first experiences?
2	What are some of the services or tasks you perform as a peer support?
3	How have you seen peer services evolve in Michigan over the last 5 years?
4	How has the integration of peer services impacted clients or consumers from your perspective?
5	How has the integration of peer services impacted other professionals or organizations from your perspective?
6	What impact has working with others with mental health and/or substance use disorders had on your own recovery?

Table 1: Interview Questions.

Once transcribed, the transcripts went through independent coding by two separate graduate assistants, and then lead researchers. This was done using content analysis methodology, to first identify clusters of responses, and those clusters or content areas with greater frequency [50]. Then the lead researchers completed a second round of coding, to collapse content clusters, finalize the list of content areas to the most frequently mentioned by participants, and compare to the literature for areas in which the findings confirmed or refuted other literature on peer services. Content clusters refer to the manifest or most direct content [51], which was useful in describing the pathways for co-occurring peer professionals and add to the initial evidence. In some cases, peer professional participants directly noted what they saw as themes, or more latent meaning within content categories. In those instances, themes were noted. However, further thematic analysis was left out to allow the peer professional voices to be heard more directly.

The participants included 15 unique individuals who were interviewed, all adults, and all of whom had been co-occurring peer support providers for at least one year, and over half for more than five years. Nine participants identified as female and six as male, and racial and ethnic identity composition was described as one Native American Indian, one Latinx, two African American, and eleven Caucasian. Participants worked variably for community mental health organizations, peer-run organizations, or veteran's organizations.

Interviews took place in person for 13 participants and by phone for two participants, due to their preference. In-person interviews took place at the peers' work sites or offices, at the lead researchers' office, or at local restaurants or coffee shops. Including the informed consent process, interviews took between 50-90 minutes total. Participants spoke to a surprisingly wide array of populations, including individuals with mental illness, substance use disorders, and chronic physical illnesses, and commonly more than one co-occurring illness. Practice settings were varied in community settings, including libraries where peer support and opioid overdose prevention services were available. Other organizational settings were also common, including community outreach with clients to access housing, court services, recovery community support, or benefits coordination. Other participants practiced primarily in jails, emergency departments, or inpatient psychiatric and medical settings, and increasingly were called in to provide "inreach", as one participant stated, following a psychiatric or substance use crisis. Specific mention of trauma-informed services and integration within evidence-based practice teams were noted [52].

Results

Before reviewing the discreet content categories shared during the interviews, it was illuminating to hear from participants about both the history of their co-occurring peer support career, and what roles they have held and tasks them performed, which varied substantially. Although the tasks performed were highly variable, there was frequently a description of the tasks as a mutual and reciprocal process, rather than the sometimes "top down" description of work provided by non-peer case managers, colleagues who provide many of the same functions as peer professionals. Participants described tasks of advocacy, in explaining people's rights and benefits, advocating directly alongside to assure access, and often doing things with clients so that they could do them a second time independently.

There were six categories of responses identified in the content analysis, which were noted in all 15 participants for the first two, more than half for the next two, and by less than half of the participants for the last two. These categories are arranged with number of participants endorsing in Table 2, and reviewed below in order of frequency. The two most commonly noted content categories were taking the Role of a Bridge-Builder, and Personal Recovery Impact. Each of these content categories was discussed by all 15 participants.

Number of participants identified	Theme Identified
15	Building bridges between clients and other behavioral health professionals.
15	Role of Peer Support Professional having a positive impact on participant's own recovery.
12	Lack of understanding of capability of people with behavioral health conditions
10	Future career aspirations developed as a result of role as a peer support professional.
7	Barriers within the system that impact role as a peer support professional.
6	Building trust, rapport, or hope with clients.

Table 2: Content Theme Responses and Frequency.

Role of Bridge-Builder

Each participant saw themselves in a role of bridging professional services to people who may lack trust in them initially. Several participants discussed this in their own experience as a service recipient, of lacking trust in the system or in non-peer providers. Participants expressed this content best directly:

"I think I have seen right from the get-go that people have told me directly that they were glad that they were able to work with somebody who understands exactly what it feels like to be where they're at" - CD0219.

"It's making that connection because my story is genuine. When you go and see a clinician, they can't really share personal experience" - JK0918.

This role of bridge-builder was infused with the peer professionals' own experience on recovery from co-occurring disorders. One possibility is that co-occurring peers have likely had to navigate mental health and substance use systems which are segmented, and provide only parallel or sequential treatment, having to build bridges in their own recovery, and then helping others does the same. In addition, the role of bridge-builder extended beyond connecting individuals in service, and to connecting mental health and substance use services to one another by advocacy with individuals with co-occurring needs.

Personal Recovery Impact

A second content category mentioned by each of the participants related to the role of peer support provider impacting one's own recovery process. This concept of working with people with behavioral health illnesses creates a consistent reminder that peer professionals' own recovery is both valuable, and not a given if not cared for.

"It keeps me in touch with my own recovery in a sense that I understand how addiction is and how fast things would fall apart for me if I started to use again" - CD0219.

"I met all these cool people who had mental illness who were looking to make a difference and help other people. I thought 'wow, this is where I'm supposed to be.'" - CH0918.

"How can I give advice to someone else on their own life if I'm not willing to follow that advice myself?" - MP0818

This awareness of the role of self in the professional role, and the critical nature of self-care to prevent burnout and cope with secondary stress is an increasing area of focus for all behavioral health providers. Peer support providers seem to understand this at perhaps a more visceral level however, and the at times life and death consequences of not caring for themselves. Another interesting note that has not been seen in other literature is the draw that some participants had to becoming a peer professional after receiving peer services themselves. This was especially noted by co-occurring peers who worked at peer-run organizations. There was a discussion of a progression between coming to the peer organization, finding out more about recovery, and solidifying one's own recovery with the specific goal of being a peer themselves; the expression "if they can do it, maybe I can too" was used in different ways several times. This concept of efficacy and hope in recovery created by working with peer professionals is seen throughout the literature, but never from the perspective of a peer professional who was once a peer recipient.

Stigma and Discrimination

The next most often mentioned content category, discussed by 12 of 15 participants, was a lack of belief by society at large, and within systems of care, in the capabilities of people with behavioral health conditions. This was often expressed in a desire to advocate for individuals with behavioral health conditions so that the system could support their recovery, and that stigma did not get in the way of recovery. Again, there was a sense that peers were proud of their significant role in modeling and working within and sometimes against systems, which gave people erroneous messages about both illness and recovery.

"Media gives hopeless, inaccurate portrayal of mental health" – JK0918.

"I feel like we can get people sober but the real problem now a days is keeping people sober because of the discrimination from society" - DC0918.

"For recovery coaches that are clean and sober; It's easier to define. There is a celebration day for addiction. But recovery for people from mental health is much more ambiguous... So it's very difficult if there's a lot of judgement"-MP0219.

In addition to the broader societal stigma, participants also recognized that there was tension in their own role at times vis-à-vis their colleagues, which is also related to a low expectation of people with behavioral health conditions, in this case the co-occurring peer professionals themselves. Some participants worked in the same systems where they had once been served, typically when they were at a much more tenuous point in their recovery. The worry that they felt or were perceived as more aligned with clients than other professionals was present in many interviews. Also, the idea that even amongst well-meaning colleagues, peer professionals were still thought of more as clients and that if a peer had a bad week; the perception would be different than if a non-peer colleague had the same experience.

Career Pathways

Despite some of these challenges in systems, ten of 15 participants wanted to advance their careers. Many discussed the support they received, and how their colleagues often made them aspire to additional training, skills, and jobs. Several participants spoke about their aspirations to complete additional certification, training competency, and go to or return to college for undergraduate or graduate degrees. Three participants talked about not just pursuing advanced career paths as peer support providers, but also creating their own jobs by starting organizations themselves to address housing and criminal justice issues.

Organizational and Policy Barriers

The next most common content category, noted by seven of 15 participants involved barriers in policies and organizations to peer support work. This is related to policies and practices involving the background needed to qualify as a peer support provider, namely having been served in the public as opposed to the private mental health system [53], as well as the requirement in some cases that peer support providers must not have criminal records.

"I remember when I used to work with XXXX County to try and find a peer for their jail. And they said, 'Oh we can't have anyone who has any criminal justice history working in our jails.' And I said, 'Well then they're not a peer.'" - AR0918

In co-occurring peer services specifically, this construct of wanting someone to be a peer but also not to have accrued any of the losses and background that goes along with the experience of being in recovery from a co-occurring disorder were also mentioned. This was noted in organizational policies related to background and drug-free workplaces. Organizations wanted peer professionals to work in the criminal justice and specialty court systems, but wanted peers with squeaky clean records. Organizations often had to look at their policies related to substance use in the workplace; if a co-occurring peer professional had a lapse back to active substance use, what did that mean? Were they fired, sent to treatment, or were their difficulties ignored?
Barriers to entering the profession of peer support were discussed in different ways, but the content indicated that policies and systems can be specifically restrictive for co-occurring peer professionals. Several participants spoke about the barriers to their entry into the peer profession as co-occurring peers. Many entered the profession either through mental health or addictions services. Interviewees discussed their role in making agencies they worked for more co-occurring capable, in part by example that co-occurring disorders and recovery existed in them as a living example.

Emblem of Hope

A content category mentioned by six of 15 participants was the process of developing rapport or hope with those they served as a peer support provider. Several participants spoke to 'the emblem of hope' that working with a peer represented for them, and that they represented to the people they served in their current roles. As two participants stated:

"It has been very good for newly diagnosed folks to see other people working and having a normal life" - DM0918
"When you're sick, at certain points the only places where you see people that identify with the same illness as you is the hospital, the AFC home, and the doctor's office. So I met some people that said 'yeah, I have these struggles, but I was able to get it under control, and now I can help other people'"-MP0219

Even though this specific theme was less common, it points out as Davidson L, et al. [31] did that a problem of behavioral health care is that most of the people that you interact with are either fellow patients, or professionals you are working with, rather than peers that can point to recovery as a possibility. Based upon the previous research on this topic, it was surprising that this was the least frequently identified category in the content analysis, and could be related to the co-occurring area of practice, which has employed mutual support groups as a core modality for a long time. Or perhaps it is just that the hope is so intertwined with the experience of being a peer and receiving peer services that it goes without mention among the participants.

Discussion

There is a substantive body of evidence on the positive outcomes for clients served by mental health and co-occurring peer services, whether offered within interprofessional teams, or as peer-run services (see Davidson L, et al. [10] and Repper J, et al. [17] for reviews). There is also a large body of work related to the implementation of peer professionals in a variety of practice settings, including the facilitators and barriers from a systems perspective [54,55]. There is less evaluation of the impact of peer services on the mental health peers themselves or the workforce [38,39,41], however this evidence is growing rapidly. The gap in the research that this study proposed to begin to fill was regarding peers in co-occurring services. This study adds to the literature by intentionally seeking the voice of co-occurring peer professionals on their perception of their work on themselves, colleagues, and clients. These findings affirm the previous work referencing the strong sense of purpose and belongingness that peer support providers feel, and create for their clients [32,33], as well as some of the struggles to belong in the workforce [14]. Newer studies

speak to micro aggressions that peers experience [56], which fall into negative messages about the nature of having a mental illness and the role of peer support specialists.

Among the confirmatory findings within a new co-occurring space, several new findings emerged. Those include the entry points of many participants through either solely mental health or substance use services, and having the experience of needing to assist their organization in co-occurring capability and development. In addition, the path of several people of becoming peer support professionals after being the recipient of peer services was novel. Finally, the discrimination and microaggressions experienced by some non-peer colleagues was not new, but the discussion of specific policy barriers to peer work, including difficulty with entry based upon legal or substance use history, were. Although these are not surprising findings for a discipline that is increasingly embedded within co-occurring behavioral health services, peer support providers who have been in the field for several years are challenging unjust practices, and becoming involved in not only advocacy with clients, but with policy-makers as well by engaging in risk-conscience activities [57]. The codification of peer services in many co-occurring organizations is going through iterative processes like all professions.

There are several specific strengths of this study. The narrative interview design allowed for an exchange and reflection about the nature of the peer discipline that made the content and process of interviews rich. Several participants noted appreciating being asked, and recognizing trends in their careers as they actively engaged in the interviews. Although that was not the only objective of the methods selected, it helped underscore the critical work of the peer field in changing the system as well as individual clients. While this study brings a new perspective to the research on peer support services, it has limitations as well. The primary limitation is the lack of generalizability due to a sample size of 15 participants. In addition to a relatively small n, due to the nature of the snowball sampling and advertisement for the study in a finite number of organizations, there is the possibility of a less reflective group of participants than the peer workforce as a whole. Another limitation relates to the potential for bias, as the lead researchers are also clinicians in the region, who may have other overlapping relationships with participants. Four of the participants had worked as a colleague with one or both of the researchers prior to participating in the study. It is possible that, even with the informed consent processes in place, participants might not share the more negative aspects of working with non-peer colleagues, or otherwise adjusted responses to what they thought would please interviewers.

Conclusion

The findings of this study contribute to our knowledge of the growth and change of the scope of peer services in one region, in both mental health and substance use services. In addition, these findings underscore the role of peer support providers as an emblem of recovery to those seeking recovery themselves, and to the hope they inspire in those with chronic illnesses. Finally, the purpose that the participants themselves feel, and the importance they place on managing their own wellness adds to our understanding of the values and needs of the peer workforce.

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