

Cooptation of Peer Support Staff: Quantitative Evidence

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ABSTRACT

OBJECTIVE: In 2007, the Centers for Medicare and Medicaid Services (CMS) sent a letter to state Medicaid directors outlining requirements for implementing peer-based recovery support services (P-BRSS) as a Medicaid-funded service. Since then, 30 states have implemented these services. Although the literature describing implementation of P-BRSS has identified the cooptation of peer support staff (PSS) as a barrier to the effective provision of P-BRSS, the evidence for it remains anecdotal. This study attempts to determine if the context of employment in either a treatment organization or peer organization affected cooptation.

METHODS: We conducted a survey of PSS in the fall of 2013. In all, 92 of the 181 respondents were working as PSS at the time, 53 in treatment organizations. Chi-square analysis was used to determine if the context of employment had an effect on the cooptation of peer staff.

RESULTS: Peer staff working in treatment organizations reported that they were supervised by treatment staff and participated in employment-related training to improve their skills at providing treatment services more frequently than their counterparts in peer organizations. Peer staff working in treatment organizations also participated in training and education to prepare for employment as treatment professionals more frequently than peer staff working in peer organizations.

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE: Peer staff members working in treatment organizations are subject to processes of acculturation into professional cultures that peer staff working in peer organizations are not. Effective implementation of P-BRSS should include specific efforts to minimize the cooptation of peer staff.

KEYWORDS: recovery, peer support, supervision, cooptation

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In 2007, the Centers for Medicare and Medicaid Services (CMS) issued a letter providing guidance to states wishing to fund the provision of peer-based recovery support services (P-BRSS) through their Medicaid programs.¹ Through this step, the federal government formally established P-BRSS as a component of recovery-oriented systems of care in the United States. This recognition occurred in unison with efforts by the Substance Abuse and Mental Health Administration of the United States Department of Health and Human Services to promulgate authoritative information regarding the development, implementation, and evaluation of P-BRSS.^{2–4} Since

then, 30 states have implemented P-BRSS as a reimbursable service in their Medicaid system and others are either moving to do so or considering it.⁵

Prior to these developments, a number of authors had reported on the implementation of P-BRSS and noted barriers to establishing the services in traditionally organized behavioral health settings.^{6–14} One of the barriers to providing P-BRS consistently identified in this, and subsequent, literature is that of “cooptation”^{14–17} or “professionalization,”^{3,18,19} the adoption of values, attributes, and style of personal interaction associated with professionally credentialed



staff members by peer staff members. Mead and MacNeil¹⁷ provide an image of this process in their description of "... a drift towards more traditional service practices." Although the issue of cooptation of peer staff members consistently emerges in discussions about the development of P-BRSS in recovery-oriented systems of care, no research is currently available describing if cooptation of peer staff members does, in fact, occur.

Background

In the United States, the state of Arizona has been a leader in integrating P-BRSS into the publicly funded system of care. Since 2003, the Arizona Department of Health Services (ADHS) has promoted the implementation of P-BRSS by encouraging traditionally organized providers of behavioral health services to append P-BRSS to their menu of services and by developing organizations specifically for the provision of P-BRSS.²⁰ These organizations, community service agencies (CSAs), are certified, rather than licensed, by the ADHS to provide only P-BRS. CSAs are usually administered and staffed by persons who identify themselves as peers, and they are referred as peer- and family-run organizations (PFROs). Treatment organizations are licensed by the state in a separate process, and provide a full range of behavioral health services. Importantly, only licensed treatment organizations are allowed to provide intakes for persons entering the state's system of care and develop service plans. The treatment organizations then refer persons to CSAs for P-BRSS when the need for such services is identified in service plans.

During the initial effort to implement P-BRSS in the statewide system of care, ADHS had encouraged treatment organizations to provide P-BRSS as well as treatment services. As the number of PFROs increased, friction grew between the two types of organizations when treatment organizations sometimes preferred to refer persons seeking P-BRSS to their own services rather than those offered by the PFROs. Although the state's intention when encouraging both types of organizations to develop P-BRSS had been to create choice for participants in the system of care, instances where treatment organizations provided P-BRSS to large numbers of persons while making no referrals to PFROs in the vicinity suggested that the treatment organizations had very little motivation to make these referrals. The lack of referrals to PFROs threatened the viability of some of these organizations.

The conflict between PFROs and treatment organizations resulting from this situation led to a series of meetings attended by PFROs from throughout the state seeking to address the lack of referrals for services and a separate set of meetings including both PFROs and treatment organizations in the southern part of the state to address the same situation. In both series of meetings, the PFROs asserted that a qualitative difference exists in the P-BRSS provided by treatment organizations and that offered by PFROs.

This difference came to be described by participants in the meetings between treatment providers and PFROs from the southern part of the state as resulting from the "... legal, ethical and clinical cultural framework of the (treatment) Agencies..."²¹

These concerns on the part of the PFROs mirror those found in the literature describing effective P-BRSS. Both the practitioners involved in the provision of P-BRSS in Arizona and the scholars examining the provision of P-BRSS in a number of settings caution that peers brought into the "legal, ethical and clinical cultural framework" of treatment organizations will experience acculturation and, through that process, surrender the very attributes that recommended their participation in behavioral health systems of care to begin with. In spite of the broad agreement about the detrimental impact that employment with treatment organizations can have on the department of peer staff, we are unaware of any work attempting to verify if such an impact does, in fact, exist.

The authors of this article are employed by a CSA involved in the development and provision of P-BRSS in southern Arizona and participated in both the statewide and southern Arizona meetings regarding the provision of P-BRSS. During the course of the discussion in both sets of meetings it became apparent that, although the representatives of the CSAs had a wealth of anecdotal information regarding the cooptation of peer support staff (PSS) working within treatment organizations, no one had any sort of quantitative data confirming that PSS working in treatment organizations become more professional in their approach to service delivery. This paper represents an initial attempt to use quantitative methods to determine if PSS do acculturate to treatment organizations by answering the research question, "Do PSS working in treatment organizations acculturate to professional treatment culture?"

Method

Data collection. We created an instrument using Survey Monkey, a Web-based survey tool. The instrument in this study included 36 questions and was designed to collect information describing (1) how participating in the culture of treatment organizations might encourage PSS to adopt treatment-oriented values by emphasizing the treatment process over the recovery process and (2) the impact these interactions may have on PSS attitudes about their roles in treatment organizations. In all, 5 of the questions collected demographic data, 6 collected data describing the behavioral health conditions of respondents that led them to identify as 'peers', 3 asked about employment preparation and employment status, 19 asked about the respondents' experience at their place of employment, 2 asked about previous employment or employment seeking, and 1 collected e-mail addresses from those willing to provide them. Survey Monkey allowed us to download the e-mail addresses separately from the other data to conduct the survey anonymously. These procedures were described to the respondents prior to their deciding if they wished to



complete the survey. The research protocol was determined to be exempt according to 45 CFR 46.101(b) per category 2 by an independent institutional review board, Salus IRB. The IRB also approved a waiver of informed consent.

Recruitment of participants. Survey respondents were recruited through e-mail contact with persons engaged as peer support specialists, representatives of organizations providing P-BRSS, or training people to provide P-BRSS who are professionally associated with the authors. Additional respondents were recruited through searching the Internet for organizations providing P-BRSS, peer advocacy organizations, and state agencies involved in the development and/or implementation of P-BRSS.

Respondents accessed the survey electronically using a link forwarded by e-mail to prospective respondents by either one of the authors or via a person who had been contacted by the authors. The survey was available online from August 27, 2013 to September 27, 2013. In all, 181 respondents completed the instrument, 92 of whom (51%) were employed as PSS at the time.

Data analysis. The organizations employing study participants were categorized as either “treatment organizations” or “peer organizations” based on the type of services they provide. The organizations providing services that would require licensure as behavioral health organizations by the state of Arizona were classified as treatment organizations under the assumption they are subject to the legal, ethical, and clinical cultural framework referred to earlier. The organizations providing services that would require certification as a CSA by the state of Arizona were classified as peer organizations. Data were analyzed using chi-square tests of independence to determine if the responses between PSS working in peer organizations and those working in treatment organizations differed, $P < 0.05$.

Results

Participant characteristics. A majority of study participants identified themselves as female (59.1%) and White (61.9%). A total of 28.2% of participants identified themselves as African American, and 5.0% as Native American. Of the 92 respondents who were employed at the time they completed the survey, 89 reported the type of organization in which they were employed. In all, 53 participants (59.6%) were employed by treatment organizations.

Employment context. The data in this section of the paper describe aspects of the employment context that might encourage PSS to acculturate to the culture of treatment organizations.

Supervision. A total of 77.4% of PSS working in treatment organizations reported that they received supervision from treatment providers and 17.0% responded that they were “not sure” if their supervisor was a treatment provider. In all, 86.1% of PSS in peer organizations reported receiving supervision from a PSS. This difference in the background of supervisors was significant, $X_2(2, N = 89) = 60.39, P = 0.000$.

Training. A total of 84.9% of PSS in treatment organizations and 97.2% of PSS in peer organizations reported that they received training to help them provide P-BRSS. No significant difference was found between the types of organization for PSS participation in training to increase their skills providing P-BRSS, $X_2(2, N = 89) = 3.64, P = 0.162$. However, the same percentage of PSS in treatment organizations, 84.9%, reported receiving training to help them provide treatment services while only 50% of PSS in peer organizations reported receiving such training. The difference between the two groups’ participation in training to provide treatment was a significant difference, $X_2(3, N = 89) = 18.19, P = 0.000$.

Hours worked. In all, 22.2% of PSS working in peer organizations reported working less than 30 hours per week, compared to 37.8% of PSS working in treatment organizations. This difference in hours worked was significant, $X_2(3, N = 89) = 8.13, P = 0.043$.

Length of time employed. The two groups of PSS reported different lengths of time employed in their current jobs. In all, 65.4% of PSS in treatment organizations had been in their jobs for one or more years, compared to 50.0% of PSS in peer organizations. This was a significant difference, $X_2(6, N = 88) = 14.01, P = 0.029$. The difference in the length of employment between the two groups is highlighted by considering that the mode for length of employment among PSS in treatment organizations is three or more years, while for PSS in peer organizations it is 1 year.

Changes in employment. The data in this section of the paper describe efforts by PSS to change their employment situation.

Training for a job in a different organization. In all, 40.4% of PSS employed in treatment organizations reported they were participating in training or educational activities that will prepare them to apply for employment in a different organization, while only 16.7% of PSS working in peer organizations were engaged in training or education to prepare them for other employment. The difference in the rate of participation in training was significant, $X_2(1, N = 88) = 5.63, P = 0.018$.

Applying for a treatment job in a different organization. In all, 39.1% of PSS employed in treatment organizations reported that they were participating in training or educational activities that will prepare them to apply for employment as a treatment provider, while only 16.7% of PSS working in peer organizations reported that they were preparing for employment as a treatment provider. This difference in the rate that respondents were preparing to apply for employment as treatment providers was significant, $X_2(2, N = 80) = 7.56, P = 0.023$.

Discussion

Employment context. In the survey sample, 77% of the PSS working in treatment organizations reported that they are supervised by treatment staff members and participated in employment-related training to increase their abilities to



provide treatment services at a much higher rate than PSS working in peer organizations. In practice, this means that the PSS employed in treatment organizations receive guidance and direction from credentialed treatment professionals, people who have consciously embraced the treatment culture. Although the current study did not include any attempt to define the nature of this supervision, the training of the professionally credentialed treatment staff members providing it included exposure to clinically oriented supervisory models. In a widely used book on clinical supervision, Bernard and Goodyear²² define one of two “central purposes” of supervision: “To foster the supervisee’s professional development—a supportive and educational function” (p. 13). While we do not claim that the supervision provided by PSS in treatment organizations is necessarily clinical in nature, it is clear that the culture of treatment organizations includes an understanding of supervision in treatment matters as explicitly incorporating efforts to guide the professional development of the supervisees. When the supervisees are PSS, efforts to professionalize their interactions with service participants diminish the value of the P-BRSS they provide.^{3,17}

In addition to receiving supervision from treatment staff members, 85% of the PSS working in treatment organizations also reported receiving training intended to increase their knowledge of the treatment methods used in the organizations in which they work, while only half of the PSS working in peer organizations reported having received training to provide treatment services. The provision of training of this sort is clearly intended to move PSS toward professional models of service provision.

The combination of supervision and training reported by PSS in this study can reasonably be construed as a powerful force encouraging acculturation into the cultures of the treatment organizations in which they work. This may also suggest that PSS in treatment organizations are perceived as “helpers” to the treatment staff members, a situation reported in the literature,^{5,8,13} and, consequently, in need of basic skills to perform this function. The possibility that treatment staff view PSS as “helpers” rather than providers of a separate set of services is reinforced by the fact that PSS in treatment organizations are much more likely to work part-time than PSS in peer organizations.

Finally, the data presented here indicate that PSS working in treatment organizations are much more likely than those working in peer organizations to engage in education or training that will prepare them to apply for jobs as treatment professionals. The desire among PSS working in treatment organizations to move into professional roles strongly suggests that they recognize the secondary status of PSS in these organizations.

Conclusions

The evidence presented here indicates that the issue of cooptation identified in the literature describing P-BRSS does, indeed,

affect the provision of PSS and that this effect is most pronounced when PSS work in treatment organizations. These conclusions are tempered by the sample selection process employed in the study and would be strengthened by the application of a more rigorous experimental design. Additionally, information describing the perceptions of treatment providers working with PSS would provide a more complete description of the experience of PSS working in treatment settings, as would detailed information regarding processes of supervising PSS used by both treatment organizations and peer-run organizations.

In spite of these shortcomings, our research indicates that steps should be taken to minimize or, if possible, eliminate the conditions that contribute to cooptation of PSS. These steps can include providing P-BRSS through peer-run organizations, tailoring the supervision of PSS to emphasize the non-professional nature of the services they provide, providing training specifically designed to enhance skills that support the provision of P-BRSS, and explicitly defining P-BRSS as separate from, and complimentary to, treatment services. These efforts can be undertaken at both the organization and system levels to enhance the quality of the P-BRSS provided.

Author Contributions

Conceived and designed the experiments: AJA. Analyzed the data: AJA. Wrote the first draft of the manuscript: AJA. Contributed to the writing of the manuscript: AJA, RRP. Agree with manuscript results and conclusions: AJA, RRP. Jointly developed the structure and arguments for the paper: AJA, RRP. Made critical revisions and approved final version: AJA, RRP. All authors reviewed and approved of the final manuscript.

REFERENCES

1. Smith DG. State Medicaid Director Letter (SMDL) #07-011. United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Baltimore, MD: 2007.
2. Center for Substance Abuse Treatment. *What are Peer Recovery Support Services?* (HHS Publication No. (SMA) 09-4454). Rockville, MD: Substance Abuse and Mental Health Services Administration; 2009.
3. Kaplan L. *The Role of Recovery Support Services in Recovery-Oriented Systems of Care*. DHHS Publication No. (SMA) 08-4315. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration; 2008.
4. Belnap D, Gueronniere G. *Financing recovery support services: review and analysis of funding recovery support services and policy recommendations*. In: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, ed. *Partners for Recovery Initiative*. Rockville, MD: Legal Action Center, & Abt Associates; 2010.
5. Vestal C. *Peers’ Seen Easing Mental Health Worker Shortage*, 2013. Available at <http://www.pewstates.org/projects/stateline/headlines/peers-seen-easing-mental-health-worker-shortage-85899504010>
6. Bluebird G. *Paving New Ground: Peers Working in In-Patient Settings*. Alexandria, VA: National Technical Assistance Center, National Association of State Mental Health Directors; 2006.
7. Campbell J, Leaver J. *Emerging New Practices in Organized Peer Support*: National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors. Alexandria, VA; 2003.
8. Chinman M, Hamilton A, Butler B, Knight E, Murray S, Young A. *Mental Health Consumer Providers: A Guide for Clinical Staff*. Santa Monica, CA: RAND Corporation; 2008.
9. Davidson L, Chinman M, Sells D, Rowe M. Peer support among adults with serious mental illness: a report from the field. *Schizophr Bull*. 2006;32(3):8.



10. Dixon L, Krauss N, Lehman A. Consumers as service providers: the promise and challenge. *Community Ment Health J.* 1994;30(6):615–625.
11. Mowbray CT, Moxley DP, Thrasher S, et al. Consumers as community support providers: issues created by role innovation. *Community Ment Health J.* 1996; 32(1):47–67.
12. Salzer MS. Consumer empowerment in mental health organizations: concept, benefits, and impediments. *Adm Policy Ment Health.* 1997;24(5):425–434.
13. Salzer MS. *Best Practice Guidelines for Consumer-Delivered Services.* Peoria, IL: Behavioral Health Recovery Management Project; 2002.
14. Solomon P. Peer support/peer provided services: underlying processes, benefits, and critical ingredients. *Psychiatr Rehabil J.* 2004;27(4):392–402.
15. Alberta AJ, Ploski RR, Carlson SL. Addressing challenges to providing peer-based recovery support. *J Behav Health Serv Res.* 2012;39(4):481–491.
16. Harrington S. Peer Support: Challenges and Possibilities. Paper presented at: Peer Support and Peer Providers: Redefining Mental Health Recovery, Teleconference. Baltimore, MD; 2010.
17. Mead S, MacNeil C. Peer support: what makes it unique? *Int J Psychosoc Rehabil.* 2006;10(2):29–37.
18. Davidson L, Chinman M, Kloos B, Weingarten R, Stayner D, Kreamer Tebes J. Peer support among individuals with severe mental illness: a review of the evidence. *Clin Psychol Sci Pract.* 1999;6(2):165–187.
19. White WL, Boyle M, Loveland D. Recovery from addiction and from mental illness: shared and contrasting lessons. In: Ralph RO, Corrigan PW eds. *Recovery in Mental Illness: Broadening Our Understanding of Wellness.* Washington: American Psychological Association. Washington, DC; 2004:233–258.
20. Division of Behavioral Health Services. *Peer Workers/Recovery Support Specialists within Behavioral Health Agencies.* Arizona Department of Health Services, Division of Behavioral Health Services. Phoenix, AZ; 2007.
21. Alberta AJ, Gray J. Dual-Emphasis Peer-Based Recovery Support Implementation and Evaluation; 2013, Manuscript in preparation.
22. Bernard JM, Goodyear RK. *Fundamentals of Clinical Supervision.* 5th ed. Pearson. New York; 2013.