THE EXPERIENCES OF PEER SUPPORT SPECIALISTS SUPERVISED

BY NON-PEER SUPERVISORS

by

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Non-peer Supervisors

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Dedication

This dissertation is dedicated to all the staff of Baltic Street Advocacy, Employment, and Housing, Inc. who for twenty-five plus years have dedicated themselves to sharing their experience, strength and hope to others like themselves on the journey towards recovery from a diagnosis of mental illness. This is also dedicated to family and friends who encouraged and supported me on this journey.

TABLE OF CONTENTS

Abstract

This qualitative study examines the experiences of peer support specialists (PSS) supervised by non-peer supervisors (NPS) in adult community mental health settings. Participants completed a demographic survey designed to address inclusionary criteria. From those eligible, a random number generator was used to select participants who would be interviewed using a semi structured interview guide. The critical incident technique was used to elicit memorable experiences of supervision. Data was analyzed thematically. Twenty interviews were completed before saturation was reached.

Thematic analysis revealed eight major themes which are best understood in the context of the ongoing transformation of mental health services from the traditional medical model to a recovery-oriented model. Those eight themes were supervisor attitudes, role integration, trauma informed supervisory techniques, facilitative/supportive environment, perspective taking, mutual learning, opportunities for peer networking and the desire for a supervisor who was a more experienced peer support worker. The supervisor's attitude was a critical factor in providing what PSS perceived as adequate supervision. An attitude of respect for the peer role combined synergistically with positive nonjudgmental communication to create a facilitative/supportive environment. That environment supported autonomous functioning which in turn worked to address role integration and suggest trauma informed supervisory techniques.

Peer Support Specialists are integrating into a mental health service system transitioning from a medical model to a recovery-oriented model of care. PSS are the embodiment of recovery. The experiences of PSS reflect the challenges inherent in role

innovation. NPS are the necessary guides who assist the PSS in navigating a system not yet aligned with peer values. If the mental health system is going to successfully become recovery oriented, then NPS need a unique skill set to support those with lived experience whose recovery can help point the way.

Chapter I

BACKGROUND

In the past few years, peer support has become part of the mental health landscape (Cronise, Teixeira, Rogers, & Harrington, 2016; Salzer, Schwenk, & Brusilovsky, 2010). In step with the empowerment education movement, which sought to redefine the relationship of patients and healthcare providers, health systems began moving towards a system of care that included the patient as an active participant (Anderson & Funnell, 2004; Wallerstein & Bernstein, 1988; Wallerstein & Bernstein, 1994). In a similar fashion, the location of peer support has migrated from its initial location in self-help groups to free standing peer run agencies to peer agencies working alongside traditional mental health agencies and ultimately, in the last decade, a move towards integration of peers into both health and mental health systems.

Evolution of Peer Support

Peer support is generally defined as a way of giving and receiving help from people who have similar experiences (Davidson, Bellamy, Guy, & Miller, 2012; Lammers & Happell, 2003; Mead, 2003; President's New Freedom Commission, 2003; Repper & Carter, 2011). More specifically, peer support is defined as a way of giving and receiving help from people who have similar experiences based on key principles of respect, shared responsibility and mutual agreement about what is helpful (Davidson, Bellamy, Guy, & Miller, 2013; Lammers & Happell, 2003; Mead, 2003; President's New Freedom Commission, 2003; Repper & Carter, 2010). Peer support in mental health has evolved. Originally peer support was located within self-help groups and later within

peer-run agencies. Now, peers provide peer support in a variety of settings from independent peer agencies to case management teams to inclusion in more traditional settings like partial hospitalization programs, clubhouses and drop-in centers (Salzer et al., 2010). The evolution has also been reflected in how peers refer to themselves. For example, early literature referred to such individuals as psychiatric survivors, a term connoting the low regard many had for the mental health system where they were treated (Chamberlin, 1978; Chamberlin, 1990). The moniker shifted to consumers and then to peers. Likewise, there has been a change in how peers who provide support for other peers refer to themselves. Titles have shifted from peer advocate, peer supporter, peer provider, peer support specialist, certified peer specialist and most recently to peer professional. For the purposes of this study, the term peer support specialist (PSS) will be used as it is a term commonly used as a job title for peers hired to support others with a mental health diagnosis.

It is widely accepted that peer support is a critical element of a recovery-oriented system of care (Anthony, 1993; Deegan, 1988; Lunt, 2002; President's New Freedom Commission, 2003; Ralph, 2000). Research suggests efforts to integrate into this disparate system of care bring both barriers and challenges. Given that PSS who are credentialed by their lived experience work among other professionals who are credentialed by their educational experience (Gates, Mandiberg, & Akabas, 2010; Bennetts, Pinches, Paluch, & Fossey, 2013; Budd, 1987; Chesler, 1990; Gartner & Riesman, 1982; Kemp & Henderson, 2012; Repper & Carter, 2010; Smith et al., 2016; Vandewalle et al., 2016). Much of the current literature studying barriers and challenges

to integration suggests that supervision is a key component of successful integration. There is little known about the supervision of PSS in general or about PSS supervision by non-peer professionals. There is currently no empirical literature which addresses the experiences of PSS receiving supervision. Data suggests that the trend of peers working as PSS alongside non-peer mental health professionals continues to grow (Chapman, Blash, & Chan, 2015). Given this trend, there is a need to understand whether supervision by a non-peer meets the supervisory needs of a PSS when integrating into a clinical adult mental health team (Middleton, Stanton, & Renouf, 2004).

In this chapter, the history leading to the current mental health landscape, the empirical studies of peer support, differences in peer and professional perspectives, and establishment of what is currently understood about the challenges of peer integration will be presented. Additionally, the framework of clinical supervision and a 2015 report titled the Pillars of Peer Supervision (Daniels, Tunner, Powell, Fricks, & Ashenden, 2015) are employed as ways of understanding the supervision of peers by non-peer supervisors (NPS). Finally, the use of a qualitative research design is suggested as the methodology best suited to understand situations or experiences about which little is known, such as the non-peer supervision of PSS (Creswell, 2013). If peer support is to provide an efficacious service element for persons with serious mental illness, we must understand more about what supports its success and how supervision can contribute.

The Role of Recovery in the Historical Context

The mental health recovery paradigm has become a significant philosophical influence on the delivery of mental health services; however, the use of the term recovery

has varied widely. As the possibility of recovery was introduced into mental health systems through the writings of proponents and through documents such as the President's New Freedom Commission (2003), mental health service providers slowly began to incorporate the language and tools of recovery into mental health settings. The term recovery is used differently in different settings. For some mental health practitioners, the term may refer to expected clinical outcomes or for other practitioners, it may refer to a philosophy or attitude that casts doubt about viewing all serious mental illness as a chronic condition (Anthony, 1993; Deegan, 1988; Harding, Brooks, Ashikaga, Strauss, & Brieier, 1987).

The concept of clinical recovery implies that a person is experiencing no signs or symptoms of mental illness, living independently, having a social life and working. In short, the individual is considered disease free. The philosophy of personal recovery as noted by Deegan (1988) and Anthony (1993) generally refers to a process whereby a person develops a new sense of self that encompasses the presence of mental illness and continues with their life. In essence, the mental illness becomes a long-term condition that must be dealt with but which does not define the individual. Recovery in the substance abuse field, for example, generally reflects a philosophical stance suggesting acceptance of abstinence from addictive substances as a goal which is achieved one day at a time (White, 2007). In this study, we will refer to recovery as personal recovery, that is the ability to live a satisfying and contributing life irrespective of ongoing symptoms and disability which is the philosophical understanding promoted by Deegan (1988) and Anthony (1993).

Until longitudinal studies such as those conducted by Harding, Brooks, Ashikaga, Strauss, and Brieier (1987a), clinical recovery was generally not considered a likely outcome for individuals with serious mental illness. This prognostic conception of serious mental illness was likely reinforced by the seemingly chronic nature of the individuals in treatment facilities. This misconception was best explained by Cohen and Cohen's, The Clinician's Illusion (1984). Essentially, clinicians do not see persons who clinically recover from severe mental illness since they no longer seek treatment. Longitudinal research suggests that persons diagnosed with mental illness can and do recover (e. g., Harding et al., 1987a). Thus the acceptance of both clinical and personal recovery as an outcome for those diagnosed with severe mental illnesses is sensible and has gained support over the past three decades (Anthony, 1993; Aschcraft & Anthony, 2006; Davidson & Strauss, 1992; Deegan, 1992; Harding et al., 1987b; Lunt, 2002; Ralph, 2000).

For those that do not clinically recover, the personal recovery paradigm outlined by Deegan (1988) and Anthony (1993) can provide an improved outcome. The idea that individuals can and do recover was also championed through the advocacy efforts of early peer leaders (McLean, 1995; Mead, Hilton, & Curtis, 2001). Contributions to the literature by many peer leaders and others expanded the understanding of personal recovery to include the idea that individuals diagnosed with mental illness had the potential to create lives that had meaning and purpose (Anthony, 1993; Chamberlain, 1990; Deegan, 1992; Fisher, 1992; McLean, 1995; Mead, 2003; Zinman, 1987). Through advocacy, peer leaders identified the perceived systematic failings of the mental health

system and came together to provide social support and self-help as a viable alternative to

what was perceived as inadequate and frequently harmful services provided in traditional

mental health service systems (Budd, 1987; Chamberlain, 1978; Deegan, 1992; Fisher,

1992; Zinman, 1987). Peer leaders became politically active and, like other marginalized

groups, demanded inclusion in policy and decision-making arenas that affected them. The

continuing advocacy for recognition of peer support has its roots in these beginning

efforts.

These advocacy goals combined with the policy movement towards a recovery

orientation to create an impetus for mental health system transformation. The Surgeon

General's 1999 Report on Mental Health suggested recovery should be the focus of the

mental health service delivery system. This report was followed by recommendations of

the President's New Freedom Commission (2003) suggesting the mental health system be

recovery oriented as well as family and peer driven. Peer support was and is uniquely

situated through its philosophy, values and advocacy to assist mental health agencies to

become recovery focused and maintain that overriding philosophy (National Ethical

Guidelines and Practice Standards for Peer Supporters, 2011).

Peer-led initiatives added a dimension to the transformation of the mental health

service system by including a variety of self-help modalities and independent peer run

services (Davidson et al., 1999; Davidson, Chinman, Sells, & Rowe, 2006; Goldman,

2000; Mowbray, Moxley, Jasper, & Howell, (Eds.), 1997). The International Association

of Peer Supporters (iNAPS, 2015) in its video entitled "What is a peer supporter?"

defines peer supporters broadly as providers with "a personal experience of recovery

from mental health, substance use, or trauma conditions who receive specialized training and supervision to guide and support others." Many studies identified the attributes and contributions of peer support. Peer support is understood as a factor in promoting wellness and autonomy with a focus on mutuality, strengths and recovery (Mead, 2003). Peer support has been shown to impact service use, satisfaction with care, quality of life and increase in hopefulness (Davidson, Chinman, Sells, & Rowe, 2006; Mead et al., 2001; Mead & McNeil, 2006; Simpson et al., 2014). The contributions peers make report on their lived experiences in the mental health system and their personal recovery journey. Their lived experience and exposure to self-help and peer support often culminates in a set of values that is often referred to as "peerness" (International Association of Peer Supporters, 2011). The literature suggests that the values and standards directing the work of peers may differ from those of licensed mental health professionals (Smith et al., 2016).

Barriers and Challenges to Integration

Multiple issues arise from the perceived differences between peer values and values espoused by mental health professionals reflected in provider responsibility. Providers are responsible ethically and legally to provide care within the standards and expectations of their specific profession (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006). It is the expertise granted through formal education in a particular profession that provides the foundation for this responsibility. Peers, on the other hand, use their lived experience as a person diagnosed with mental illness within a mental health system of care. Providers are held to certain standards or expectations of care.

Although the active ingredients of peer support have received attention in the literature, the question of how peer-led interventions successfully interact with provider-led interventions remains underexplored (Davidson & White, 2007; Hodges & Hardiman, 2006; Lammers & Happwell, 2003; Mahlke, Kramer, Becker, & Bock, 2014; Stewart, Watson, Montague, & Stevenson, 2008). Studies from over thirty years ago suggested that concerns about peer participation in mental health service delivery included perceived dangerousness of self-help groups as well as value conflicts between professional helpers (Budd, 1987; Chesler, 1990; Gartner & Riesman, 1982). Since that time, multiple studies have documented the progress peers have made in promoting self-help as well as the contributions of peer support in reducing inpatient stays and promoting recovery outcomes (Chapman, Blash, & Chan, 2015; Chinman, Young, Hassell, & Davidson,2006; Mead, Hilton, & Curtis, 2001;Mowbray, Moxley, Jasper, & Howell, 1997). Today, peer support is an expected part of the mental health service delivery system. Indeed, the evolution of understanding and acceptance of peer support is captured by a recent study of psychiatric residents who are being mentored by peers with the goal of impacting the residents understanding of recovery and reducing negative stereotypes (Agrawal et al., 2016).

Workforce Issues

However, the workforce issues facing PSS in mental health services remain multi-faceted. On the one hand, studies suggest peer work is seen as enriching, economically important and contributing to personal recovery as it allows individuals to use their expertise by experience to help individuals as well as assisting in the broader advocacy

movement and cause (Deckert & Statz-Hill, 2016; Doherty, Craig, Attafua, Boocock, & Jameson-Craig, 2004; Johnson et al., 2014). There is evidence that peer workers role model recovery, encourage choice making and empower service users to create an individualized recovery plan (Kogstad, Ekeland, & Hummelvoll, 2011). National and state policies have encouraged inclusion of peer support workers in policy making and service delivery to underscore the importance of choice and promote the vision of recovery (Bennetts, Pinches, Paluch, & Fossey (2013).

On the other hand, findings also suggest peer workers face barriers such as limited educational options, lack of role clarity and unrealistic job demands; as well as resource and institutional barriers (Bennetts et al., 2013; Goodwin & Happell, 2008; Kemp & Henderson, 2012; Lawn, Smith & Hunter, 2008; Repper & Carter, 2011; Smith et al., 2016; Vandewalle et al., 2016).

Integration of newcomers into any existing workplace setting comes with challenges. In an ideal world, a PSS would fit seamlessly into a clinical team providing services to those diagnosed with mental illness. While not always possible, the literature suggests that certain ingredients such as full support by administration, a recovery orientation and job clarity are necessary for such integration (Ashcraft & Anthony, 2006; Ashcraft & Anthony, 2009; Chinman, Young, Hassell, & Davidson, 2006; Davis, 2013; Deckert & Statz-Hill, 2017; Hamilton, Chinman, Cohen, Oberman, & Young, 2015). In a recovery-oriented service system, peerness, (i.e., an emphasis on equality, choice and self-determination through self-disclosure (SAMHSA, 2011), is understood. PSS are valued by peer and non-peer team members for their ability to inspire hope and model

recovery (Kidd, McKenzie, & Virdee, 2016; Solomon, 2004; Sowers, 2005). In the absence of a thoughtful integration plan which includes a focus on job clarity and a recovery-oriented system of service delivery, challenges and barriers can arise.

Attitudes of professionals towards PSS

Studies indicate that the persistence of attitudinal barriers create an expectation that PSS will adopt the working practices of clinicians (Happell, 2008; Happell, Bennetts, Tohota, Platania-Phung, & Wyden, 2016; Middleton et al., 2004; Watson, 2007). Medically oriented professionals, unfamiliar with the uses of lived experience, express concerns about peer workers' mental stability and express reluctance to support peer worker participation at both the individual treatment and broader system levels (Moll, Holmes, Geronimo, & Sherman, 2009; Moran, Russinova, Yim, & Sprague, 2013).

 A study by Solomon (2004) found that mental health professionals expressed difficulty accepting peers as equal members of the team. Role confusion and role competition between peer and clinical providers have been identified as barriers (Carlson, Rapp, & McDiarmid, 2001). Role confusion is often expressed by a lack of awareness of the various roles that peers can undertake. It is not uncommon for peers to be relegated tasks outside the job description of a PSS, such as van driver or activity monitor. Role competition can be expressed by the demand that peers adopt the professional culture with its academic-instilled set of norms and values that may differ from the norms and values associated with peerness (Jonikas, Solomon, & Cook, 1997; Zipple et al., 1997). Integration of peers into existing mental health teams has also prompted fears about

professional job security and possible replacement by peers (Borkman, 1990; Simpson,2013).

Studies indicate professionals are also concerned by dual relationships and a perceived lack of professional boundaries by peers employed in mental health services, which in turn put peers under suspicion of divided loyalties (Kaufman, Freund, & Wilson, 1989; Meehan, Bergen, Coveney, & Thornton, 2002). In some agencies, PSS receive their own mental health services where they work. Additionally, many professional codes of ethics forbid interaction with clients outside the work area. It is possible that PSS have prior or existing relationships with clients whom they are now expected to serve. The nature of relationships in peer support differs in significant ways from the expectations of boundaries in non-peer professional relationships.

With concerns about professional boundaries come additional fears such as lack of confidentiality, lack of empowerment, and cooptation (Alberta, Ploski, & Carlson, 2012; Bennetts et al., 2013; Carlson et al., 2001; Gates & Akabas, 2007; Hamilton et al., 2015 ; Middleton et al., 2004; Moran, Russinova, Gidugu, & Gagne, 2013). The application of how boundaries are understood by professionals to PSS relationships frequently leads to a perceived lack of empowerment by the PSS. Professionals question whether PSS can uphold expectations about confidentiality in these situations. PSS question whether acceptance of professional boundaries, as defined by non-peers, results in cooptation or accepting the norms and roles of the dominant culture.

Funding Peer Support

Despite these concerns described above, peer support services are fast becoming a part of the mental health delivery system. In 2007, the Center for Medicare and Medicaid Services (CMS) recognized peer support services as evidence-based and thus reimbursable under state Medicaid Plans. As of October, 2016, there were 25,000 PSS eligible to become part of the behavioral health workforce (Kaufman, Brooks, Steinley-Bumgarner, Stevens-Manser, 2012). Recently 42 states have approved Medicaid funding for PSS; and two more are in the process of applying (Kaufman et al., 2012; Kaufman, Kuhn, & Stevens-Manser, 2016). CMS reimbursement mechanisms call for training and certifying PSS as well the supervision of the PSS by a mental health professional as defined by each state (CMS, 2007). The requirements by CMS correspond with the recommended training and supervision that is suggested in the literature for addressing identified challenges and barriers. Yet, the nature of the supervision suggested is not clearly delineated.

Clinical Supervision versus Peer Supervision in Mental Health Services

The literature on clinical mental health supervision is robust. For the purposes of this study, clinical supervision will provide the background within which peer supervision will be examined as most mental health professionals have had experience with clinical supervision either through training or practice. Clinical supervision is typically understood as an intervention provided by a more senior member of a profession to a more junior member of that same profession (Bernard & Goodyear, 2004; Goodyear & Bernard, 1998). Provided within an explicit practice domain, clinical

supervision has the purposes of enhancing professional functioning of the more junior person, monitoring the quality of professional services offered to clients, and serving as a gatekeeper to those seeking to enter a particular profession (Bernard & Goodyear, 2004; Goodyear & Bernard, 1998; Milne, 2007; Milne, Aylott, Fitzpatrick, & Ellis, 2008). Since PSS do not belong to a explicit traditional mental health practice domain, it raises questions about their placement within a typical clinical supervision hierarchy. Are they paraprofessionals or allied professionals or something else?

For paraprofessionals, the assumption is that a paraprofessional staff member is carrying out the job duties of the professional that can be safely relegated to someone without the requisite education, degree, or license (Dawson, Phillips, & Leggat, 2012; Dawson et al., 2013; Milne, 2007; Strong et al., 2004). PSS do not fit within the definition of para- professional staff that specifically work under the license of a professional and carry out the duties delegated to them by the licensed professional. It may be that PSS fit the definition of allied professionals, for example, art therapists, dietitians, drama therapists, music therapists, occupational therapists, or those members of a health care team whose duties are distinct from nursing, medicine, social work or psychology (Spence, Wilson, Kavanagh, Strong, & Worrell, 2001). The literature suggests that allied health professionals' benefit from supervision by someone within their particular practice domain (Dawson & Leggatt, 2012; 2013). For these reasons, clinical supervision of a PSS by a NPS does not fit neatly into this generally accepted understanding of clinical supervision. Understanding the differences between supervision of PSS and clinical supervision is important to enable us to make distinctions.

Peer Supervision versus Clinical Supervision

Clinical supervision of PSS by NPS is poorly understood. PSS, using their lives as a primary experience-based intervention, function in ways that are distinct from mental health professionals. These experience-based interventions may differ from professional interventions as they may involve dual relationships, personal self-disclosure; a focus on empowerment, and role modeling hope and recovery (Davidson et al., 2013; Lammers & Happell, 2003; Mead, 2003). A review of 519 national PSS job postings on the CareerBuilder website revealed job duties including at least three elements distinct from a traditional professional role: "provide hope and encouragement by serving as a role model in recovery; provide an ongoing perspective to team members on the experience of mental illness and recovery; use their recovery story as it relates to the peer support relationship" (Career Builder, PSS job description retrieved 4/17/17).

Given these distinctions in job tasks, the probable differences in peer supervision by NPS include not occurring within an explicit professional practice domain, not being delegated job duties of his/her profession to be carried out by the PSS as a junior member of the profession, paraprofessional or allied professional. The broader concept of peer supervision is used to connote members of the same profession providing supervision for one another. Although there are anecdotal instances of PSS supervising other PSS, the empirical literature is non-existent.

As noted above, some aspects of a peer's role such as personal self-disclosure may directly conflict with professional training NPS has received. These differences create the potential for a miscommunication or worse in the supervisory process between

a PSS and NPS. Since there is scant literature on supervision between a PSS and NPS, it is important to begin to understand the experience to determine what possible supervisory processes, content and aims exist. The available current literature on peer supervision suggests supervision as an avenue to role clarity and possible job satisfaction (Davis, 2015; Delman & Klodnick, 2016; Kuhn, Bellinger, Stevens-Manser, & Kaufman, 2015).

Problem Statement

Much of the current literature on challenges and barriers to peer integration, and hence PSS effectiveness in their role, suggests that supervision is a key component to successful integration (Delman & Klodnick, 2016; Gates & Akabas, 2007; Gates et al., 2010). Although the literature on clinical supervision is robust, to date there is little known about the supervision of PSS by NPS. This qualitative study will seek to discover more about the experiences of PSS supervised by NPS by asking the following research questions:

Main Question: What are the supervision experiences of PSS supervised by NPS in adult community mental health settings?

Sub-Questions: What do PSS think the role of supervision is in providing peer support services? What are the perceptions of PSS about how supervision by NPS influences their work?

Significance and Purpose

There appear to be potential differences between typical clinical supervision and the supervision of peers by non-peers. Inherent in clinical supervision is the goal of role-

modeling practice behaviors for the less experienced supervisee and thus assisting the

supervisee to increase their expertise (Goodyear & Bernard, 1998). The NPS in all

likelihood has not had the experience of accomplishing peer goals or interacting as a

peer, making it difficult to role model for a peer. Since there is little known about the

experiences of PSS supervised by NPS, this study will seek to contribute to an

understanding not only of the basic experience itself but also about the elements

perceived as important in supervision between a peer and NPS. If supervision is a

necessary component for successful integration of PSS into mental health teams, then

understanding more about what goes on in supervision is a step towards defining what is

necessary for success.

The stated goal of mental health service transformation (e.g., Presidents New

Freedom Commission) is to provide recovery-oriented services in a context that is

individualized and person centered versus system centered and under professional

control. An additional goal of mental health services has been to increase the employment

opportunities of persons diagnosed with mental illness (Bond, Drake, Meuser, & Becker,

1997; Meuser & McGurk, 2014). Individuals with a diagnosis of mental illness want to

work and many want to work as peers. Employment as a PSS offers a path to the

accomplishment of these goals. As peers have entered the workforce, and as CMS has

acknowledged the work of PSS as a best practice, more needs to be understood about the

process and purpose of supervision as a remedy to identified peer workforce issues.

Given the continued trend towards integrating peers into the traditional mental health

workforce, it is important to understand how NPS support the unique role of the PSS

through supervision.

Such an understanding of the experience of PSS in supervision with NPS has the

potential to identify issues that are important to effective supervisory practice. This study

potentially provides a beginning for other research that looks at important content or

processes that lead to job satisfaction and job retention. It is possible that an outcome of

this study may be to understand more about what factors contribute to effectiveness in

supervision. This study may provide data on what appears as a potential disconnect

between non-peers supervising peers. It may be that this is not perceived as a problem for

peers or their NPS. It is more likely however that there are some problems, but what these

problems are remains unknown. Equally unknown is whether some NPS have found

solutions to some of these problems.

Research Design

Qualitative research is well suited for the exploration of an issue about which

little is known (Creswell, 2013). A qualitative approach will examine how these

individuals interpret their experience and ultimately construct and attribute meaning to

their experiences (Creswell, 2013; Merriam & Tisdell, 2016; Padgett, 2008; Patton,

2002). The critical incident technique (CIT) will be used as a data collection strategy

within the interviews followed by thematic analysis of responses to interview questions

(Flanaghan, 1954; Vaismoradi, Turunen, & Bondas, 2013).

 CIT will be used to collect data about memorable supervisory incidents

(Flanaghan, 1954). CIT requires that participants recall in as much detail as possible one

or more particular incidents including specific details of the situation, the action and the outcome. In this study, the focus will be on recalling times when supervision was memorable and the reasons for recalling the incident as memorable. To obtain specificity and richness, the participants will be asked to recall as much detail as possible about the incident or incidents they are recounting.

Conceptual Definitions

According to iNAPS (2015), a PSS is a person with a personal experience of recovery from mental health, substance use, or trauma conditions who receives specialized training and supervision to guide and support others with lived experience of mental illness and is employed to provide peer support services. For the purposes of this study, NPS is a mental health professional such as a psychiatrist, psychologist, social worker, psychiatric nurse or mental health counselor who does not have a diagnosis of mental illness or has not disclosed. Such supervision is broadly defined here as a meeting held between a peer and NPS identified as supervision that meets the expectations of the workplace in which it takes place (iNAPS, 2015). Adult community mental health settings will include such settings as outreach teams, case management teams, ACT teams and partial hospital settings. CIT is a set of procedures used for collecting information about human behavior that has critical significance and meets methodically defined criteria (Flanaghan, 1954).

Assumptions and Limitations

Due to the small sample and methods of this study, results will not be generalizable beyond the specific population from which the sample was drawn (i.e., PSS

in the US. It is expected that sufficient detail will be provided through thick descriptions

of the findings and an audit trail for readers to determine the extent with which the results

are transferable. The study is only looking at PSS in adult, community-based mental

health settings. PSS working in other settings may produce different results. Supervision

between PSS and supervisors who are peers themselves is not being studied. The

regulations governing payment for peer support services requires that PSS be supervised

by a mental health professional as defined by each state. Because of this requirement, the

majority of the future PSS workforce will in all likelihood be supervised by NPS.

Limitations also possibly include investigator bias and analytic bias, both of which will

be addressed through reflexivity and other processes of ensuring trustworthiness.

Summary

If the future of mental health is to remain recovery focused and if, as the

President's New Freedom Commission (2003) suggests, the voice of peers and families

need to be represented in a transformed system, then successful inclusion of peer

providers in treatment models is critical. Some studies suggest that supervision is key to

successful integration, job satisfaction and retention (Davis, 2013; Davis, 2015; Delman

& Klodnick, 2016). There is currently no specific theoretical understanding of the key

components of supervision between the PSS with lived experience and the NPS. As a

first step of empirical understanding, this study has the potential to pave the way for

subsequent research which addresses questions of supervisory effectiveness and purpose.

Chapter II

REVIEW OF THE LITERATURE

Personal recovery as an outcome for those diagnosed with severe mental illness has gained acceptance over the past three decades (Anthony, 1993; Deegan, 1992; Harding et al., 1987b; Lunt, 2002; Ralph, 2000). Studies establish the effectiveness of peer support and its place as a guiding principle in the recovery paradigm (Chamberlain, 1990; Deegan, 1988; Fisher, 1992; McLean, 1995; Mead, 2003; Zinman, 1987). Increasingly, policy guidelines recommend inclusion of consumers and their families in policy making and service delivery. Increasing numbers of mental health systems have begun to employ peers as members of clinical teams.

Peer integration brings with it challenges that the current literature suggests can be addressed through training and supervision. However, there is little empirical literature that addresses the topic of supervision of PSS. The purpose of this study is to understand the experiences of PSS supervised by NPS. Funding through Medicaid requires PSS supervision by a mental health professional as defined by each state (Center for Medicare and Medicaid Services, 2007). The literature also suggests that an allied health professional benefits from supervision by someone within their particular practice domain (Dawson & Leggatt, 2012; 2013). If peer support within traditional mental health systems, is to provide an efficacious service element for persons with serious mental illness we must understand more about what supports its success and how supervision can contribute.

Peer Support

Peer support is defined as a way of giving and receiving help from people who have similar experiences (Davidson et al., 2013; Lammers & Happell, 2003; Mead, 2003; President's New Freedom Commission, 2003; Repper & Carter, 2011). Peer support in mental health has evolved. The evolution was first reflected in how peers refer to themselves. For example, early literature referred to such individuals as psychiatric survivors, a term connoting the low regard many had to the mental health system where they were treated (Chamberlin, 1978; Chamberlin, 1990). The moniker shifted to consumers and eventually to peers. It would seem that the shifting title reflected the evolution of how peers saw themselves located within the mental health system as well as how the mental health system recognized them as a potential workforce.

The locations of peer support provision have also evolved. In 1948, consumers and ex-patients banded together to establish Fountain House, one of the first clubhouses providing services by peers for peers (Doyle, Lanoil, & Dudek, 2013). The evolution of peer support was multifaceted (Mowbray, Moxley, Thrasher, Bybee, & Harris, 1996). Of significance, the clubhouse movement succeeded in gaining support to produce alternative programs based on a philosophy of consumer empowerment and run entirely by consumers or ex-patients (McClean, 1995). The federally sponsored Joint Commission on Mental Illness and Health's report entitled Action for Mental Health (1961) noted the role of ex-patient groups and suggested support for these alternatives. However, peer support, located within clubhouses, self-help groups, and other stand-alone peer run agencies, was slow to be included in traditional mental health service systems (Borkman,

1990; Chamberlin, 1978; Estroff, 1982; Fukui, Davidson, Holter, & Rapp, 2010;

Kaufmann et al., 1989). Advocacy in the United States and in other countries by

consumers and ex-patients continues to challenge the assumptions and negative

consequences of traditional mental health practice and its control by professionals

(Happell et al., 2016).

Peers now work in a variety of settings from independent peer agencies to case

management teams to inclusion in more traditional settings like inpatient units, partial

hospitalization programs, case management teams, clubhouses, residential settings and

drop-in centers (Salzer et al., 2010). Likewise, there has been a change in how peers who

provide support for other peers refer to themselves. Titles have shifted from peer

advocate, peer supporter, PSS, certified peer specialist and most recently to peer

professional. According to the iNAPS (2015),

…peer support providers are people with a personal experience of recovery from mental
health, who receive specialized training and supervision to guide and support others who
are experiencing similar mental health, substance use or trauma issues toward increased
wellness (retrieved from a video on iNAPS Website, 5/15/2018).
Regardless of how PSS roles are labelled, the characteristics associated with peer

support and thus with peer support workers have remained fairly constant. Since the

1990's, studies sought to identify the characteristics and contributions of peer support.

The iNAPS' practice guidelines (2016), adopted by the Substance Abuse and Mental

Health Services Administration (SAMHSA), suggest that ideally peer support is

requested, not assigned. It is also mutual and reciprocal, strengths focused, transparent,

person driven and between persons who share power equally. iNAPS (2016) goes on to

note that PSS are hopeful, open minded, empathetic, respectful, honest and direct.

Characteristics of peer support as reported in the literature support this view and include:

a focus on hope and personal recovery; a role model of success negotiating mental health

systems; a different approach to empathy; a focus on client's strengths; use of principles

of respect, shared responsibility and mutual agreement about what is helpful (Daniels,

Tunner, Powell, Fricks, & Ashenden, 2015; Davidson et al., 1999; Davidson et al., 2013;

Lammers & Happell, 2003; Mowbray et al., 1997; Salzer, 1997). Peer support also

includes an emphasis on self-determination, personal responsibility, health and wellness

as well as broader advocacy issues such as person-provider interaction and stigma (Salzer

et al., 2010). A recent task analysis study of PSS and case managers identified consumer

empowerment, and personal and educational development as a part of the realm of peer

support workers (Crane, Lepicki & Knudsen, 2017).

It is important to be mindful of these unique characteristics of PSS as the

employment of peers in different traditional mental health settings has created varieties of

peer support, some involving unidirectional support and others providing peer-led

traditional mental health services. A recent study by Bellamy, Schmutte, and Davidson

(2017) finds these distinctions between professional services and peer services are based

explicitly and directly on shared experiences and the reciprocity of mutual experiences.

The efficacy of peer support continues to be cited in multiple studies with

findings suggesting positive impact on service engagement, satisfaction with care, quality

of life and increase in hopefulness (Chinman et al, 2014; Davidson, O'Connell, Tondora,

Styron, & Kangas, 2006; Mead, 2003; Mowbray et al., 1997; Salzer, 1997; Salzer, 2002).

An update of this evidence by Bellamy et al. (2017) confirms the findings that peer

support services are equal in outcome to those services provided by non-peer professionals. Not only does this study underscore previous findings which suggest peer support services impact hospitalization rates but it also suggests PSS services have a positive impact on hope, empowerment and quality of life; all factors associated with personal recovery for service users (Deegan, 1988).

It is widely accepted that peer support is a critical element of a recovery-oriented systems of care (Anthony, 1993; Deegan, 1988; Lunt, 2002; President's New Freedom Commission, 2003; Ralph, 2000). PSS bring to the mental health system a focus on choice, empowerment, education and a belief that lives with meaning and dignity can be regained (Deegan, 1988). PSS role model personal recovery through their lived experience.

Recovery

As mentioned earlier, the term recovery is understood in different ways. The concept of clinical recovery implies that a person is experiencing no signs or symptoms of their mental illness. Clinical recovery was not viewed as a possibility for persons diagnosed with severe mental illnesses until the emergence of longitudinal research studies (e.g., Harding et al., 1987). The longitudinal research studies by Harding et al. (1987) found that after 30 years 25% of individuals diagnosed with schizophrenia had fully clinically recovered and another 35% were functioning independently in the community. The personal recovery philosophy articulated by Deegan (1988) and Anthony (1995) refers to a person's journey to a life, with or without symptoms, that has purpose and meaning. Deegan (1988) articulated the philosophical underpinnings of

personal recovery, noting that it is "recovering a new sense of self and of purpose within and beyond the limits of the disability" (p. 11). A recovery orientation such as this is viewed as fundamental to a transformed mental health service system (Anthony, 1993; Aschcraft & Anthony, 2009). In this study, personal recovery is meant to refer to the philosophical understanding promoted by Anthony (1993) and Deegan (1988).

Hope is recognized as a critical precursor to personal recovery (Simpson et al., 2014). Peers have unique abilities to convey hope through sharing their experiences in the mental health system and their own personal recovery process. Mental health professionals can share that expectation and vision but are less uniquely suited to embody that promise. PSS, however, embody what Deegan (1988) refers to as "the three cornerstones of recovery; hope, willingness, and responsible action" (p.14). Through modeling these cornerstones, the PSS offers hope and a pathway to personal recovery.

These unique characteristics distinguish peer support from professional intervention. The contributions peers make differ as a result of their lived experiences in the mental health system and their personal recovery journey (Davidson et al., 1997; Davidson et al., 2001; Mead, Hilton, & Curtis, 2001; Mead & McNeil, 2006; Simpson et al., 2014; Smith et al., 2016). It is not that non-peer professionals cannot demonstrate respect, attempt shared responsibility or mutually agree on what is helpful. It is that peers use their own lived experience in the mental health system to demonstrate a place of mutuality.

Peers who are experiencing recovery themselves are considered uniquely positioned to both explain and model the personal recovery journey. Even mental health

professionals who support the concept of personal recovery can be at a loss about how to direct the process. Some mental health professionals are unconvinced that any recovery is a possibility. The belief that recovery is an artifact of misdiagnosis remains imbedded in some of the traditional mental health system (Braslow, 2013; Harding & Zahniser, 1994). Braslow (2013) suggests in *The Manufacture of Recovery* that the origins of a belief in recovery derive less from the ideas espoused by peer advocates than from a medically driven treatment philosophy propelled by the rise of deinstitutionalization and the availability of effective psychopharmacology.

Disbelief of personal recovery, discrimination, and the demands of provider responsibility by some non-peer staff are barriers that can prevent mental health professionals from providing the hope and recovery perspective that is necessary to alter the self-stigmatizing perceptions held by so many of those diagnosed with mental illness (Davidson, Haglund, Stayner, Rakfeldt, Chinman, & Tebes, 2001; Wang, Link, Corrigan, Davidson, & Flanagan, 2017). Stigmatization and discrimination against those diagnosed with mental illness does not necessarily end with their employment as PSS (Morgan, Reavley, Jorm, & Beatson, 2016). It is possible that these differences in perspectives may contribute to the barriers and challenges experienced as PSS integrate into adult community mental health teams (Jonikas, Solomon, & Cook, 1997; Solomon, 2004; Zipple et al., 1997).

Integration of Peer Support Specialists into the Mental Health Workforce

As PSS began to work alongside traditional mental health professionals, barriers and challenges became apparent. Studies suggest PSS work is enriching, challenging,

economically important, contributes to personal recovery and allows individuals to use

their experience to assist others (Deckert & Statz-Hill, 2016; Daniels et al., 2013;

Doherty et al., 2004; Johnson et al., 2014). A study by Basto, Pratt, Gill and Barrett

(2000) suggests that PSS perceive a higher level of organizational support and in turn

express a higher level of commitment to the employing organization than non-peers.

   Both PSS and professionals identify barriers and challenges to successful

integration (Ashcraft & Anthony, 2012; Garrison, Ackerson, & Forrest, 2010).

Challenges to collaboration and integration take many forms. These challenges are

sometimes reflected in job interviews where peers presenting for employment as PSS are

expected to be in personal recovery. Not only is there no current literature to guide

employers on identifying those applicants in personal recovery, but professionals are

limited in their ability to ask questions specifically about the history and diagnostic

qualifications that may support the applicants' claim of personal recovery. Anecdotally, it

is often a request to have the applicant describe how they would share their story of

personal recovery that makes it possible for professionals to decide who to hire. One

cited barrier is professional staff attitudes (Gates, Mandiberg, & Akabas, 2010; Happell,

2008; Nestor & Galletly, 2008; Vandewalle et al., 2016). Negative staff attitudes can be

expressed through discrimination or stigmatizing behaviors. The literature continues to

suggest that staff attitudes can also reflect perceived differences between PSS values and

provider responsibilities (Budd, 1987; Shields, Scully, Sulman, Borba, Trinh, & Singer,

2019; Siantz, Rice, Henwood, & Palinkas; Simpson, Oster, & Muir-Cochrane,

2018;Villotti, Zaniboni, Corbiere, Guay, & Fraccaroli, 2018). Early on, there were studies

suggesting provider concerns about perceived dangerousness of self-help underscoring value conflicts between professionals and peers (Chesler, 1990; Gartner & Riesman, 1982). It was suggested that PSS uneducated in assessment, may miss potentially dangerous signs and symptoms. More recent studies suggest that conflicts continue between peers and professionals over differences in values and perspective, but place more emphasis on issues of role clarity (Cabral, Strother, Muhr, Sefton, & Savageau, 2014; Clossey, Gillen, Frankel, & Hernandez, 2016).

Medically oriented professionals, unfamiliar with the benefits of the use of lived experience, express ambivalence about PSS participation at both the individual treatment and broader system levels (Moll et al., 2009; Moran et al., 2013). Early on, there were studies suggesting provider concerns about the perceived dangerousness of self-help underscoring value conflicts between professionals and peers (Chesler, 1990; Gartner & Riesman, 1982). It was suggested that PSS uneducated in psychological assessment, may miss potentially dangerous signs and symptoms. More recent studies suggest that conflicts continue between peers and professionals over differences in values and perspective, but place more emphasis on issues of role clarity (Cabral, Strother, Muhr, Sefton, & Savageau, 2014; Clossey, Gillen, Frankel, & Hernandez, 2016). Other studies suggest the persistence of expectations by professional that a peer will fit in with the traditional values and norms of mental health services (Happell, 2008; Lammers & Happell, 2003; Middleton et al., 2004; Watson, 2007). Such concerns may diminish the use of self-disclosure and other tools associated with peer support.

The stigmatization of people diagnosed with a mental illness does not necessarily end when they become employed as colleagues within a clinical team (Kemp & Henderson, 2012; Nestor & Galletly, 2008; Moran et al., 2013; Vanderwalle et al., 2016; Waynor & Pratt, 2012). A frequently cited concern of professional staff is the PSS mental stability (Moll et al., 2009; Nestor & Galletly, 2008; Waynor & Pratt, 2012). Relapse is not uncommon among those diagnosed with mental illness especially in the early stages (Robinson et al., 1999). Data regarding rates of relapse among individuals who are in personal recovery as defined by Deegan (1988) and Anthony (1993) and seeking employment as PSS is absent in the current literature. Nonetheless, professional staff can become preoccupied with monitoring PSS mental status for signs of decompensation. Another concern expressed by non-peer providers is the perceived lack of professional boundaries by peers employed in mental health services (Kemp & Henderson, 2012; Meehan et al., 2002; Moll et al., 2009).

 Concerns about PSS ability to maintain professional boundaries include the potential for dual relationships, confidentiality breaches, and role conflicts (Alberta et al., 2012; Bennetts et al., 2013; Carlson et al., 2001; Gates et al., 2010; Hamilton et al., 2015; Middleton et al., 2004; Moran et al., 2013). Dual relationships, the existence of previously existing relationships or relationships with clients outside the workplace, is an ongoing challenge for peers attempting to integrate into professionally dominated settings (Carlson et al., 2001; Gates et al., 2010; Garrison, 2010). Such relationships, common among self-help groups and peer run organizations are frequently discouraged or

forbidden by professional ethical guidelines. Many of these concerns can be subsumed under a lack of job clarity.

Lack of job clarity, role confusion and role competition between peer and clinical providers is a significant barrier to integration (Asad & Chreim, 2016; Carlson, Rapp, & McDiarmid, 2001; Davis, 2015; Gates et al., 2010; Hamilton et al., 2015). Often the employing mental health organization has a vague PSS job description or lacks awareness of the various roles that peers can undertake. Team members may not fully understand the PSS role and therefore express concerns about being replaced. A study focused on the unique and common role elements between case managers (CM) and PSS underscored the uniqueness of the PSS role in empowering clients and promoting personal growth, although CM may overlap with PSS in care coordination activities (Crane, Lepicki, & Knudsen, 2016).

Studies suggest barriers such as limited educational and peer supervision options, low pay, and lack of advancement result in limited job tenure (Bennetts et al., 2013; Kemp & Henderson, 2012; Repper & Carter; 2011; Smith et al., 2016; Vandewalle et al., 2016). There are also interpersonal challenges such as cooptation, lack of empowerment, trying to belong, social isolation, and conflict inherent in advocacy (Alberta et al., 2012; Assad & Chreim, 2016; Bennetts et al., 2013; Watson, 2007). All these findings suggest the barriers to integration can be significant.

However, the literature notes that many professionals recognize the benefits of PSS, even if they do not recognize the PSS' status as equal team members (Barrett, Pratt, Basto, & Gill, 2000; Waynor & Pratt, 2012). Recent studies suggest that professionals

understand the unique PSS role of educating service users about recovery and the value

placed on PSS by service users (Cabral, Strother, Muhr, Sefton, & Savageau, 2014).

Mancini (2017) concludes that the factors of role clarity, autonomy and acceptance by

non-peer coworkers are essential to successful integration. Supervision is suggested as a

necessary component to successful integration of PSS into mental health settings

(Carlson et al., 2001; Chinman et al., 2006; Gates & Akabas, 2007; Kemp & Henderson,

2012; Kuhn et al., 2015; Moran et al., 2013; Oh & Solomon, 2010; Smith et al., 2016;

Wolf, Lawrence, Ryan, & Hoge 2010; Vanderwalle et al., 2016).

Supervision of Peer Support Specialists

Although supervision of a PSS by a mental health professional is a requirement

for Medicaid funding, there is little guidance in the empirical literature to address the

purpose, content or process of supervision of PSS. Chinman (2014) defined peer support

supervision in the following way:

Peer Support Supervision occurs when a peer support supervisor and peer support
specialist supervisee(s) formally meet to discuss and review the work and experience of
the peer provider, with the aim of supporting the peer in their professional role (p.15).

Much of the current literature on peer supervision suggests supervision as an

avenue to role clarity. A study by Delman and Klodnick (2016) suggests that supervision

is essential for providing job clarity to peers. A study by Davis (2015) further suggests

that regularly scheduled supervision and frequency of supervision were predictive of role

clarity. Other studies suggest that the primary indicator of job satisfaction for PSS is the

supervisor's understanding of the PSS job role (Kuhn et al., 2015). Oh and Solomon

(2010) suggest the use of role-playing in supervision is a useful tool for assessing and

teaching peers. Although the findings are limited in the empirical literature, the grey literature offers more information.

The grey literature offers recommendations in a document entitled Pillars of Peer Support: Peer Specialist Supervision (the Pillars) (Daniels, Turner, Bergeson, Ashenden, Fricks, & Powell, 2015). The Pillars of Peer Support Supervision represent the sixth of a series of summits wherein experts in the field came together to produce recommendations intended to support the development of the PSS workforce. The recommendations were reached by a consensus process based on discussion among those who were actively trying to address the issue of peer supervision either within their agencies or within their states. The recommendations from the Pillars were intended to provide guidance to states and other entities asking how best to provide supervision for the peer support workforce. The Pillars were widely distributed by the National Association of State Mental Health Program Directors and thus served as a valuable tool. These recommendations are broad. The Pillars suggest that the supervisor should be trained in quality supervision skills; the supervisor should understand and support the role of the peer specialist; the supervisor should advocate for peer specialists and peer services within and without the organization and finally, the supervisor should promote both the professional and personal growth of the peer specialist. Websites such as iNAPS (2015) and the Depression and Bipolar Support Alliance (DBSA) (2018) also suggest guidelines for providing peer supervision. These sources do not delineate whether these guidelines pertain to peer supervision in general or to supervision by a non-peer professional as well.

Clinical Supervision and Peer Supervision

The majority of mental health professionals have been exposed to a form of clinical supervision through academic training and experience. The primary mental health professions such as psychiatry, psychology, nursing, social work and counseling recognize clinical supervision as a component of practice (Gold, 2004; Jones, 2006; McCarthy, Kulakowski, & Kenfield, 1994; Wheeler & Richards, 2007).

The broadest definition of supervision refers to "a working alliance between two or more professional members where the intention of the interaction is to enhance the knowledge, skills, and attitudes of at least one staff member." (Spence et al., 2001, p. 141). According to Bernard and Goodyear's (2004) definition, clinical supervision is generally understood in the traditional mental health milieu as occurring between a senior member and a junior member of a certain profession or between an expert in the profession and its unlicensed allied health professionals. When viewed as an intervention provided by a more senior member of a profession to a more junior member, supervision has the purposes of enhancing professional functioning of the more junior person, monitoring the quality of professional services offered to clients and serving as a gatekeeper to those seeking to enter a particular profession (Bernard & Goodyear, 2004; Milne, 2007; Milne et al, 2008). A more liberal understanding includes the idea that supervision advances professional and personal development in a supportive relationship among equals (Butterworth, Bishop, & Carson, 1996).

Other purposes of supervision are reflected in how it serves the institution where it takes place. In this regard, the literature on supervision suggests that supervision can be

divided into three main purposes: administrative/managerial, educational and restorative (Bernard & Goodyear, 2004; Goodyear & Bernard, 1998). Studies suggest that these functions are frequently combined (Manthorpe, Moriarty, Hussein, Stevens, & Sharpe, 2015). Administrative or managerial supervision is understood to focus on ensuring that the rules and regulations, licensure requirements and other agency initiatives are followed by the supervisee (Bernard & Goodyear, 2004; Karpenko & Gidycz, 2012; Kavanagh, Spence et al., 2001). Educational supervision encompasses the notion that there are skills and understandings to be transmitted from a more experienced supervisor to a less experienced supervisee (Bernard & Goodyear, 2004; Kavanagh, et al., 2002; Kilminster & Jolly, 2000). Restorative supervision is frequently cited as those aspects of supervision which prevent job burnout and improve job satisfaction and retention (Bernard & Goodyear, 2004; Kavanagh, et al., 2002).

The literature on supervision in general suggests a lack of full understanding about what makes supervision effective and directly linked to positive outcomes for clients (Allen, Szollos, & Williams, 1986; Barnett, Erickson, Goodyear, & Lichtenberg, 2007; Kavanagh et al., 2002; Spence et al., 2001). However, there is some consensus that effective supervision includes characteristics such as trustworthiness, good people skills, ability to listen, open minded, flexible, and supportive of personal growth (Allen, Szollos, & Williams, 1986; Falender et al., 2004; Manthorpe, Moriarty, Hussein, Stevens, & Sharpe, 2015). Despite the inability to link supervision and its impact on professional practice, the idea of supervision as an essential component of an institution's structure remains established (Buus & Gonge, 2009). Literature suggests that supervision can be

correlated with a number of outcomes. Some studies suggest that supervision is a

component of job satisfaction and retention for employees (Kavanagh et al., 2003). Other

studies suggest that inexperienced practitioners prefer direct supervision related to

learning skills (Stoltenberg, McNeill, & Crethar, 1994). The literature pertaining to

clinical supervision further suggests that the supervisory relationship itself is an essential

component to effective supervision (Jones, 2006; Ladany, Mori, & Mehr, 2013).

While the NPS may have experience in clinical supervision, there is no empirical

evidence to suggest whether that skill or competency in clinical supervision transfers to

supervisory roles with a PSS. The literature does suggest that these competencies in

supervision may carry over to the supervision of paraprofessionals when they are

carrying out the job duties of the professional that have been safely delegated to them

(Dawson et al., 2012; Kavanagh et al., 2003; Milne, 2007; Milne et al., 2008; Strong et

al., 2004). Furthermore, when compared to clinical supervision, the Pillars are similar in

only two of the five recommendations made for peer supervision: supervisors should be

trained in quality supervisory skills and supervisors should promote both the personal and

professional growth of the supervisee (Daniels et al., 2015).

Supervision of PSS does not appear to fit this clinical supervision model. As

noted earlier, PSS function in ways distinct from mental health professionals using what

is frequently called peerness (i.e., an emphasis on equality, choice, dual relationships,

empowerment, credibility, hope and personal recovery) with self-disclosure as a primary

intervention (Davidson et al., 2013; Lammers & Happell, 2003; Mead, 2003). As a result,

if supervision is understood as the teaching of skills required in a specific professional

role or relegating job duties, there may be a mismatch between a non-peer professional and a PSS supervisee.

Research Questions

The primary research question is: What are the experiences of PSS supervised by NPS in adult community mental health settings? Sub-Questions: How do PSS understand the role of supervision in providing peer support services? What are the perceptions of PSS about how supervision by NPS influences their work? Given my experience in working with PSS, I expect that there would be distinct differences in perspective about how the PSS and NPS understand the help services users need and subsequently that would create conflict in supervision.

Qualitative Research Design

Qualitative research is a method of inquiry that allows for the exploration of an issue or experience grounded in the human experience (Corbin & Strauss, 2008; Creswell, 2013; Denzin & Lincoln, 2008). Anchored in a constructivist philosophical position, qualitative research is concerned with how people experience their world. The central thinking behind this epistemological paradigm is that reality is socially and culturally constructed (Creswell, 2013; Haverkamp & Young, 2007; Lincoln & Guba, 1985). The intent of qualitative research is to study an interaction or experience from a holistic rather than a reductionist point of view. The emphasis is on exploration, discovery and description which is essential to begin to understand a phenomenon about which little is known such as the experience of PSS supervised by non-peers (Denzin & Lincoln, 2008; Maxwell, 1992; Merriam, 1995).

Therefore, in practice the questions posed to participants were open ended and general, allowing for participants to construct the meaning of their lived situation. In contrast to quantitative research, which frequently seeks to address a specific hypothesis and address relationships or correlations, qualitative research seeks to understand experiences, thoughts and processes of people as they live through situations (Haverkamp & Young, 2007). Additionally, in contrast to quantitative research, the opinions and background of the principal investigator (PI) represent information that needs to be considered as well as a bias inherent in the research. As the PI, I have a Masters in Psychiatric Nursing and a career in a progressive community mental health center. I am the co-founder of Baltic Street A.E.H., Inc, a peer run agency, and I have supervised peers for the majority of my career. This bias is addressed through reflexivity, a process of bracketing, journaling, and reflection which acknowledges that researchers are part of the social world they are attempting to study (Anney, 2014; Corbin & Strauss, 2008; Koch,1988).

Critical Incident Technique

The critical incident technique (CIT) described by John Flanaghan (1954) is designed to look at a particular incident or experience with the goal of identifying processes to improve the expected outcome. Initially, CIT was used as a tool for solving specific pilot error problems during World War II, but since then has been used extensively in the areas of health science and education (Butterfield, Borgen, Amudsen, & Maglio, 2005; Fitzgerald, Seale, Kerins, & McElvaney, 2008; Kemppainen, 2000; Schulter, Seaton, & Chaboyer, 2007). By gathering observations of those experiencing a

particular situation, the CIT data collection strategy can build a clearer picture of the situation under study with a fully described situation, action and outcome. The reason to use CIT in a study such as this is to elicit data that can be used for practical purposes. Because there is so little known about the experiences of PSS supervised by non-peers, it is expected that when PSS describe a memorable supervisory experience, they will identify situations in which supervision was perceived as either positive or negative. These data will increase understanding about the current PSS supervisory experience.

The process of CIT includes a number of discrete steps: identifying the aim of the study or the research question; identification of the types of events or incidents to be collected; the data collection itself which can take many forms including individual interviews; and finally, the data analysis (Flanaghan, 1954; Schulter et al., 2007). The CIT process also included nine credibility checks which are suggested to ensure overall trustworthiness (Butterfield et al., 2005). These checks overlap in most ways with the trustworthiness protocol suggested by Braun and Clarke (2006) and used throughout this study (See Appendix D). The success of this technique depends on eliciting specific behavioral descriptions from the participants. For this study, reports of specific detailed encounters where supervision was perceived as memorable were solicited. A clear description of memorable events with antecedents, actions and behaviors involved as well as the outcome associated with the event is critical to establishing a breadth of understanding. The more incidents of memorable supervision reported in great detail the greater the likelihood that rich data will emerge inductively to support practical answers (Keatinge, 2002; Kemppainen, 2000). To obtain rich data participants were asked to

recall more than one specific memorable incident. The final step of CIT involves analyzing the data. According to CIT, analysis involves categorizing the data which was conducted using Braun and Clarke's (2006) six step method.

Obtaining rich data illuminated what elements, variables and processes best supported the role of the PSS work on adult community mental health service teams. Subsequent analysis of this rich data revealed practical suggestions from study participants. Since there is relatively little known about the content or process of supervision between a PSS and NPS, it is important to understand these experiences to provide helpful support and guidance for this developing workforce.

Ethical Considerations

Qualitative research, like all other forms of research, requires careful attention to ethics. The guidelines of the Institutional Review Board of Rutgers' University were followed, we sought and received approval for this study. An informed consent process was included to ensure that participants were fully informed. For this study, particular attention was paid to protect the identity of the participants as potentially sensitive employment related material had the potential to impact their employment status if their identity was not safeguarded. Participants were not identified by name and all interviews were held in a neutral, non-employment related setting. The employment settings themselves were described in a neutral manner so that their actual identity remains obscured (Creswell, 2013; Patton, 2002; Seidman, 2013).

Significance/Need for the Study

Since there is little known about the experiences of PSS supervised by NPS, this study seeks to contribute to an understanding of the elements both in process and content that occur in supervision between a peer and NPS. The research literature on the assimilation of peers into the workforce identifies multiple barriers and challenges faced by the peers that seek to work in adult community mental health services and those non-peer mental health professionals who work with them. This array of literature frequently suggests that training and supervision are the tools to address integration challenges. If the future of mental health is to remain recovery focused and if voice of peers and families need to be represented in a transformed system, then successful inclusion of PSS in traditional mental health teams is essential to fulfill this promise.

As the mental health system continues its transformation toward a peer driven, recovery-oriented service delivery system, PSS will likely continue as an integral part of that process. Keeping peers as a part of that evolving work force will likely remain a necessary element. It is possible that supervision can play an important role in not only supporting job retention and satisfaction for PSS, but also supporting the use of "peerness."

The guiding vision for the future of mental health is a personal recovery focused system that includes the voices of peers and families. Integrating peers into service delivery systems represents a step in that direction. As a first step of empirical understanding, this study has the potential to pave the way for subsequent research which might address questions of the effectiveness of supervision as a vehicle to address the

multitude of barriers and challenges as PSS take their place in the traditional mental

health system.

Chapter III

METHOD

Research Approach

Based on the research question, and the lack of research on the topic, a qualitative research approach was most suitable for this study. Qualitative research represents a broad approach to the study of complex phenomena grounded in the human experience (Creswell, 2013; Lincoln & Guba, 1985; Patton, 2002). The critical incident technique (CIT) was used as a data collection strategy to focus participants on the details of times when supervision was particularly memorable (Butterfield et al., 2005). This technique can assist participants to describe their thought processes and actions before, during and after the event. With the use of prompting questions, attempts were made to elicit an understanding of how participants took part in events related to supervision and why they act the way they do. Retrospective self-report has been used successfully to capture the experiences of participants in psychology, health care and education (Borgen, Hatch, & Amudsen, 1990; Keatinge, 2002; Kemppainen, 2000). Participants were encouraged to be as specific as possible about what happened before the supervision that they deemed memorable; what exactly made the supervision memorable; what happened specifically during and after and what was the outcome. Not all participants were able to recall or articulate each component of an ideal CIT response, however for this study all data collected were analyzed.

Thematic analysis was used to identify themes in the data derived from this study. Thematic analysis is a basic descriptive qualitative analysis approach suitable for

interpretive studies (Braun & Clarke, 2006; Vaismoradi et al., 2013). The thematic

analysis process involves becoming familiar with the data by reading transcripts,

generating codes, looking for patterns among the codes to create categories, and

identifying connections among the categories to discern and interpret themes (Vaismoradi

et al., 2013). In accordance with CIT, the purpose of data analysis was to reduce the data

by categorization of all the incidents (Butterfield et al., 2005). The 69 incidents obtained

from the interviews were analyzed, categorized and used to develop the final themes. It

was expected that a thematic analysis of individual interviews would extract rich

descriptive information that would shed light on important aspects of supervision from

the PSS point of view.

      The researcher in this study was the main data collection tool (Seidman, 2013).

As a result, it was important to increase trustworthiness as well as to recognize and

reduce unreasonable biases to the extent possible. Qualitative research embraces bias and

recognizes the inevitability of bias in research; the important aspect is to declare my bias

as the researcher. The use of reflexivity, journaling, ethical considerations, and other

tools to ensure overall trustworthiness are addressed in detail later in this chapter.

Participants

      Participants for this study were selected using purposeful sampling to locate

participants able to provide rich, descriptive information about the PSS' experience of

supervision by NPS (Coyne, 1997; Patton, 2002). Purposeful sampling is a qualitative

research technique used to find cases that illuminate the phenomenon of interest (Patton,

2002). Recent survey data indicated that the majority of PSS are employed in adult

community mental health settings (Blash, Chan, & Chapman, 2015). Thus, participants were employed as PSS working with adults with serious mental illness in settings, such as outreach teams, case management teams, assertive community treatment (ACT) teams and partial hospital settings. These settings represented adult community mental health systems employing a team of varied mental health professionals. Although these settings were not exactly the same, they did have similar characteristics, such as based in the community, serving adults and employing a team of varied professionals. The variety of settings contributed to the richness of the data. Merriam (1995) suggests that the use of multi-sites allows results to be applied to a greater range of other similar situations. Participants were age 18 and over, any gender, and worked in their current employment setting as a PSS for a minimum of twelve months.

Additionally, participants were receiving supervision from the same NPS for either a minimum of twelve months or had a minimum of twelve sessions with the same NPS since multiple studies on effective supervision suggest that length of time in supervision as well as frequency of supervision contribute to perceived effectiveness by participants (Allen, Szollos, & Williams, 1986; Barnett, Erickson, Goodyear, & Lichtenberg, 2007; Creaner, 2013; Edwards et al., 2005; Kavanagh, Spence, Wilson, & Crow, 2002). Thus we wanted to ensure that our participants had a sufficient accumulation of time to develop a coherent experience with their NPS. Since interviews took place via Zoom, an electronic video conferencing tool, participants needed to have access to a computer in a private setting with Internet, audio and video capabilities.

There is little consensus among experts on the sample sizes necessary in qualitative research (Boddy, 2016; Luborsky & Rubinstein, 1995; Malterud, 2001; Merriam, 1995; Patton, 2002). The number of participants recruited for this study needed to be sufficiently large to allow for attrition and to ensure enough participants with the ability to report their experiences in rich detail. When identifying and selecting an adequate sample size, the researcher needs to focus on the depth of information as the important determinant rather than a specific number (Boody, 2016; O'Reilly & Parker, 2012). Similar studies used a minimum of seven to twenty-five participants (Kemp & Henderson, 2012; Lammers & Happell, 2003). For this study, a minimum of twenty-five participants were invited to participate to ensure a robust number after attrition.

Procedure

An application was submitted to The Institutional Review Board (IRB) of Rutgers, the State University of New Jersey, for approval was sought before proceeding, IRB approval was obtained and procedures were followed throughout (Pro2018002812). In order to locate suitable participants, a purposive sampling method was used. Therefore, an invitation to participate in this study was sent to the International Association of Peer Specialists (iNAPS) for national distribution through their list serve. It was likely that iNAPS would yield individuals with knowledge and experience of the subject under study as iNAPS is an association of PSS. A letter requesting the support of iNAPS to seek participation by their members was sent (Appendix A). Once iNAPS formally agreed to participate, the REDcap survey tool including an invitation to participate and informed consent was sent to all members via the iNAPS list serve

(Appendix B). Once individuals agreed to participate, they were then asked to complete a brief demographic survey. As an incentive to participate, all respondents to the survey were entered into a drawing with a chance to win a hundred-dollar gift certificate.

The survey sent through the iNAPS list serve, https://research.njms.rutgers.edu/redcap/, was constructed to obtain informed consent and to obtain basic demographic information such as age, gender, race/ethnicity, education, employment setting, gender, race/ethnicity and profession of supervisor, employment history, supervision history and a willingness and capacity to be interviewed via Zoom. Since employment setting, age, and non-peer supervision are inclusion criteria, the demographics allowed for sampling within respondents that met the criteria. Sampling issues frequently revolve around the issue of credibility and transferability (Creswell & Miller, 2000). Gathering demographic information provided additional information with which to evaluate these parameters.

A consistent semi-structured interview guide using open-ended questions was used to obtain rich descriptions of PSS experiences in supervision by a NPS (Appendix C). With informed consent, the demographic survey and semi-structured interview guide was piloted with two PSS obtained through convenience sampling to determine if in fact the questions contained in the guide produce sufficient, in-depth data to answer the questions proposed in this study. Questions which reflect critical incident technique methodology were included (Flanaghan, 1954; Josselson & Lieblich, 2003; Keatinge, 2002; Seidman, 2013). Since little is known about the supervision of peers, it was anticipated that the use of this technique would potentially identify effective practices.

The goal was to assist participants to be as specific as possible in describing with all the relevant details of recalled incidents, either negative or positive, in supervision (Kemppainen, 2000). After receiving feedback from participants in the pilot interviews, it was decided to eliminate the sentence from the introduction about PSS in the workplace and the question-What would you add to this discussion? as it was redundant.

Data Collection

A purposeful sample was collected from respondents answering the iNAPS survey. Participants eligible for inclusion were age 18 and older, working as a PSS in adult community mental health settings, and supervised by NPS for a minimum of twelve months and a minimum of twelve supervisory sessions. There were 94 respondents to the iNAPS survey. Of the 94 respondents, 29 individual surveys were incomplete or duplicative. Of the 65 completed surveys, 26 of those did not meet the inclusion criteria. From the remaining 39 eligible participants, 25 individuals were selected for possible participation by using a random number generator. Of the original 25, eight participants did not respond to attempts to set up an interview, necessitating selecting eight replacements by random number generator.

Participants selected for interviewing were contacted to schedule interviews via the contact information provided by them in the survey tool. Next, following verification of informed consent, individual interviews were conducted via Zoom, an electronic video conferencing tool. The use of a semi-structured interview captured the components necessary to the critical incident technique: a description of the incident deemed memorable; actions or behaviors of the supervisor and peer before, during or after the

cited incident; and the perceived outcome of the supervisory session (Butterfield et al.,
2005; Flanaghan, 1954; Kemppainen, 2000). See Appendix C for specific questions.

The establishment of rapport between the researcher and the participant was a key
aspect of the interview, thus the interview began with open-ended questions and
reflective responses to reduce anxiety and establish trust and collaboration (Seidman,
2013). During the interview process, questions focused on gathering details of elicited
supervisory memories were utilized. Such questions were designed to determine exactly
what happened in the specific supervision session being recalled. It was important to
elicit the details of the session by asking about, possible significant events prior to the
session; what was talked about in the session; how did the topic come about; what was
experienced during this particular situation; what was the participants' responses to the
remembered event; and subsequent outcomes associated with the event (Flanagan, 1954;
Butterfield et al., 2005; Fitzgerald et al., 2008; Keatinge, 2002; Kemppainen, 2000;
Schluter et al., 2007). The semi-structured nature of the interview guide allowed for
prompts and clarification to support recall of specifics in the event being discussed. At
the conclusion of the interview, participants were told that they could contact the
interviewer if they would like to add or clarify comments.

Zoom interviews were conducted in a neutral setting ideally apart from the place
of employment to protect confidentiality and to eliminate concerns of repercussions of
any kind. The identity of the participant was protected throughout the interview process
as well as in reporting the results of this study. Participant identifying information was
numerically coded so that transcripts only contained the coded identifier. Video and

audio recordings were destroyed once the interviews were transcribed. All interviews

were audio and video-taped via Zoom. Each interview lasted between thirty to forty

minutes and was sufficient to gather key data. Data collected (both transcribed and

analyzed) was maintained securely in a password protected computer during this process

(See Figure 1 for data collection flowchart).

Figure 1: Data Collection Flow Chart

Goal: Purposive sampling of PSS supervised by NPS in adult community mental health settings. Received permission from iNAPS to recruit members, then a REDcap survey containing an invitation to participate, informed consent and demographic questions was sent to all members of iNAPS

Once informed consent was granted, the REDcap survey captured basic demographic information used to identify participants meeting inclusion criteria

With informed consent, the demographic survey and semi-structured interview guide was piloted with two PSS obtained through convenience sampling

Random sample of eligible participants was obtained by using a random number generator of respondents until sample of 25 is obtained

Semi-structured interviews of randomly selected participants took place via Zoom (an electronic conferencing tool) until saturation occurred. Contact information was provided for participants if they wanted to add or clarify comments post-interview.

Data Analysis

Thematic analysis of the interviews followed the steps suggested by Braun and

Clarke (2006). As interviews were completed and transcribed by the videoconferencing

transcription service, they were read and re-read in their entirety to become familiar with

the data. This step provided the researcher with an opportunity to document reflexive

thoughts or thoughts about potential preliminary codes. The next step was analyzing the

data to generate initial codes. Coding, or aggregating data into small categories of

information was performed with the assistance of NVivo 12(QSR International), a

computer software program designed to organize and sort qualitative data. Collecting

data under various subcategories was used to contribute to initial ideas about classifying

content (Braun & Clarke, 2008; Padgett, 2008; Vaismoradi et al., 2013). Initial codes

were developed from the first three interviews using NVivo12 by the principal

investigator and co-investigator independently, then discussed until consensus was

reached. A codebook served as an initial guide and repository of these emerging codes.

The repetition of ideas and categories was noted by the fourteenth interview. It was

evident that by the analysis of the seventeenth interview that no new information was

being added. Three more interviews were conducted to verify that data saturation had

been reached.

As coding progressed it was possible to begin searching through the data,

interpreting the data with the goal to reduce data to inclusive themes. Iterative analyses of

all transcripts were discussed with a co-investigator resulting in agreement on codes and

subsequent themes. Reviewing and discussing potential themes with a co-investigator

allowed for examination of the themes in relation to the whole data set. Results of theme

making were then reviewed by qualitative experts. Themes were further defined and

named in that process of discussion with qualitative experts. This assistance two other

qualitative researchers with experience in team coding was a way to triangulate data

analysis, perform peer debriefing, and establish rigor and maintain validity (Creswell &

Miller, 2000; Mathison, 1988; Merriam & Tisdell, 2016).

The result of this data analysis was to develop a beginning understanding of the

experiences of PSS in supervision with NPS and perhaps to inform practical applications

(See Appendix D for further details of data analysis).

Research Considerations

Issues of Trustworthiness

Qualitative research offers other perspectives for measuring reliability and

validity than is usually found in quantitative research (Cypress, 2017; Maxwell, 1992).

Lincoln and Guba (1985) suggest other criteria as equivalents: credibility, dependability

transferability and confirmability. These criteria plus attention to reflexivity contribute to overall trustworthiness of a study (See Appendix E for trustworthiness protocol).

Credibility

Credibility determines whether the research findings represent plausible information drawn from the participants' original data and is a correct interpretation of the participants' original views (Lincoln & Guba, 1985; Nowell, Norris, White, & Moule, 2017). Credibility was maintained through the systematic recording and transparency of the methods of analysis available to readers of the study. It was also maintained through careful interviewing, using consistent semi-structured questions and a focused awareness approach to ensure listening was in a neutral manner that helped capture participants' meaning as correctly as possible (Seidman, 2013).

Credibility was maintained in a number of other ways: participants' accounts were captured via audiotape to ensure accuracy of participant's reporting. Audiotapes were transcribed by a professional transcription service to provide yet another check on accuracy. Participants were afforded the opportunity to follow up with this interviewer to clarify previous comments or add comments (Bloomberg & Volpe, 2008; Merriam & Tisdell, 2016). As the data emerged, prolonged engagement with the data by reading and re-reading the raw data assisted in establishing credibility (Morse, Barrett, Mayan, Olson, & Spiers, 2002). A summary of data from final stages of analysis was sent to participants for review of accuracy as an additional member check. Data analysis triangulation was performed with the assistance of other researchers reviewing code, category and theme development. The assistance of other researchers also made peer debriefing possible.

Peer debriefing is a process in which those who hold impartial views of the study are included to review transcripts, coding decisions, and provide feedback as the data analysis unfolds (Morse et al., 2002). A detailed physical audit trail was created which included a journal which captures decision points, reflexivity notes and memoing on the research process (Wolf, 2003). An intellectual audit trail was created capturing the evolution of this researchers thought processes throughout the study. Sampling continued until saturation was achieved which constitutes another strategy to support credibility.

Dependability

Dependability is understood as the stability or consistency of the inquiry processes used over time (Guba & Lincoln, 1989; Morse et al., 2002). The more consistent the researcher has been in the research process, the more dependable are the results. Data analysis triangulation supports dependability as well (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014). This researcher maintained an audit trail which allowed others to assess the dependability and overall trustworthiness of the study. An auditable decision trail was made available to an impartial outside researcher included theoretical, methodological and analytic decision points throughout the study (Anney, 2014; Koch, 1988; Nowell et al., 2017; Rodgers & Cowles, 1993). All procedures were detailed and are presented here with sufficient detail to enable another researcher to replicate the study. Dependability was also accomplished by using thematic analysis and critical incident techniques which represent a qualitative research design and procedures that are well-established within the field of qualitative research.

Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts with other respondents – it is the qualitative research equivalent of generalizability (Anney, 2014). It was accomplished primarily through the use of explicit purposeful sampling and eliciting rich descriptions which were shared with the reader. It is then possible for the reader to determine whether the results are generalizable to their area of interest.

Confirmability

This concept reflects the neutrality brought to bear on the topic. It ensures that the findings are based on the respondents' reports and not the bias of the researcher. Triangulation, or a search for convergence among different sources, was achieved in multiple ways (Patton, 2002). One way was to include other researchers in the data analysis by employing team coding after the initial codes were developed; another was to maintain both an intellectual and physical audit trail that was reviewed by an independent researcher. Such a strategy minimized unreasonable researcher bias as well as creating another data vantage point (Creswell & Miller, 2000). Finally, a summary of the major findings was sent to all participants to confirm recognition of their responses as a form of member checking.

Reflexivity

Reflexivity is an integral part of efforts to establish the trustworthiness of a study. Reflexivity is the conscious effort to attend systematically to the context of knowledge construction, especially to the effect of this researcher, at every step of the research process (Creswell, 2013; Patton, 2002). Bracketing, or setting aside preconceived notions

to allow a fresh perspective of the phenomenon, was utilized (Creswell, 2013). Since the data collection instrument in this study was the researcher, it required attention to potential biases that needed to be noted and bracketed. Using reflexivity was a method that addressed this researcher's bias. (Koch, 1998).

This writer has been involved in the supervision of peers for over thirty years and as a result has had a first-hand view of the evolution of peer services from self-help meetings to stand alone agencies to the recent integration of peer services within more traditional mental health settings. As a researcher who interacted with the participants in this study, it was critically important to be aware of and document my own position on this topic in order to highlight any contribution that my own bias brought. An audit trail was kept which included a journal of reflections noted as data was gathered and analyzed as a tool to ensure trustworthiness and reflexivity (Nowell et al., 2017).

Chapter IV

RESULTS

This qualitative study explored the experiences of PSS supervised by NPS. This study also explored the perceived influences of non-peer supervision on the work of peer support and the PSS perceptions of the role of supervision. Participants were interviewed through the Zoom videoconference platform in a neutral, non-work setting of their choice. The interviews were conducted by the principal investigator using a semi-structured interview guide and lasted approximately 35-45 minutes. Thematic analysis of the interviews followed the steps suggested by Braun and Clarke (2006). Initial codes were developed from the first three interviews using NVivo12 by the principal investigator and a co-investigator independently, then discussed until consensus was reached. Iterative analyses were discussed with a co-investigator resulting in agreement on codes, categories, and subsequent themes. Results of theme making were then reviewed by qualitative experts. Data saturation began developing by the fourteenth interview. It was evident by the analysis of interview seventeen that no new information was being added. Three more interviews were conducted to verify that data saturation had been reached.

A total of 20 PSS supervised by NPS in adult community mental health settings participated in this study. All the participants were over 18 years old, 65% were females (13), 30% were males (6) and 5 % identified as other (1) (Table 1-2). Participants came from across the United States fairly evenly represented from the Northeast, Southeast,

Mid-States, Northwest and Southwest. Participants worked in a wide variety of adult community mental health settings, such as crisis services, intensive case management teams, outreach teams, community mental health center clinics, intensive case management teams, case management services, counseling/wellness centers, and a variety of psychiatric rehabilitation services. A cross tab query run on NVivo did not reveal any significant patterns between study findings and demographics.

The results of the study will be presented in a summary of findings.

Table 1.   Demographic Information

AGE	GENDER	ETHNICITY	LOCATION	EDUCATION	EMPLOYMENT SETTING
Over 18-20	Female-13	White-13	Northwest-5	Bachelors-9	Crisis-3
	Male-6	Black-3	Southwest-5	HS/GED-6	Outreach-2
	Other-1	Asian-1	Central-4	Associates-4	CM-3
		Hispanic-1	Northeast-4	Masters-1	ICM-1
		Other-2	Southeast-2		PSR-1
					PROS-1
					ARMHS-1
					CMHC-2
					PH-1
					Counseling-1
					Drop-in-2

Table 2: Demographic Information

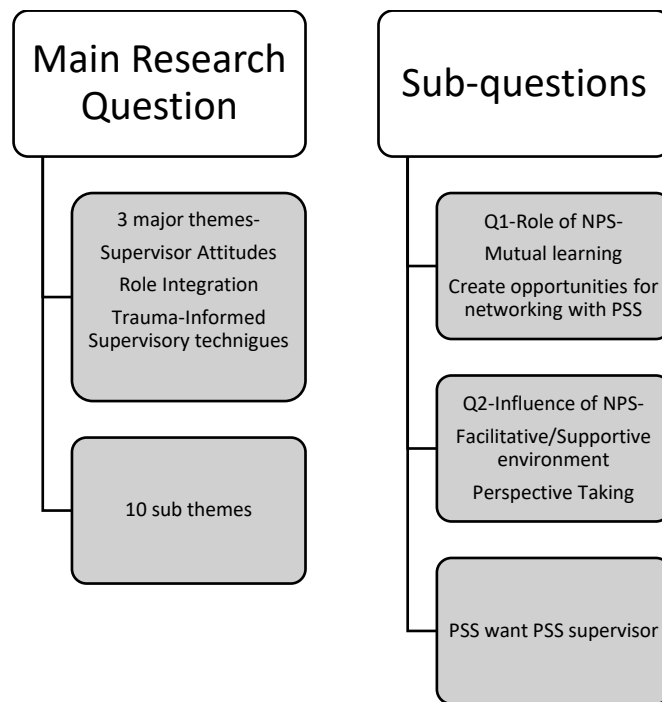| Job Satisfaction	Job Tenure	Non-peer jobs	Supervision in non-peer jobs	Profession of current supervisor	Gender of supervisor	Ethnicity of supervisor
Very satisfied-7	1-3 years-7	Yes-14	Yes-13	Administrator-8	Female-14	White-16
Moderate-7	3-6 years-7	No-6	No-2	Social worker-5	Male-6	Unknown-4
Satisfied-2	6 or more-6			MH Counselor-5		
Dissatisfied-2				Psychologist-2		

Summary of Results

Transcripts of the interviews underwent thematic analysis (Braun & Clarke, 2006). An inductive approach which requires immersion in the details of the data to identify patterns of meaning from the data itself was utilized (Patton, 2002).

In summary, many of the PSS and NPS had negotiated the relationship and for the most part participants liked their supervisor. However, the NPS attitude toward the PSS is a critical factor. Most of the participants spoke to this issue. A supervisor's attitude was either experienced in a positive or negative way. Those participants who experienced a supervisor's attitude as positive, reported feeling supported and could thrive. Additionally, role integration is at best incomplete and remains a barrier to PSS success. Participants expressed the challenges in becoming a part of the mental health team: one such challenge is negotiating different perspectives. Finally, the necessity of employing trauma informed supervisory techniques in PSS supervision was highlighted as participants expressed that their use of self, their sharing of lived experiences in working with others, required supervisors to be aware of the toll their work took on them.

The findings demonstrate that PSS have had a wide range of experiences in supervision, which range from effective (positive) to less effective (negative). Eight themes emerged from the interviews with PSS, which are (1) role integration, (2) supervisor attitudes, (3) trauma informed supervisory techniques, (4) facilitative/supportive environment, (5) perspective taking, (6) opportunities for PSS networking, (7) mutual learning, and (8) preference for a supervisor with experience as a PSS. (Table 3).

Table 3. Summary of themes and sub-themes

Main Research Question	Sub-questions
3 major themes- Supervisor Attitudes Role Integration Trauma-Informed Supervisory technigues	Q1-Role of NPS- Mutual learning Create opportunities for networking with PSS
10 sub themes	Q2-Influence of NPS- Facilitative/Supportive environment Perspective Taking
	PSS want PSS supervisor

Following is a detailed report of the findings with data extracts that represent and support the findings. Illustrative anonymous quotations taken from the interview transcripts attempt to portray these complex experiences.

Major research question: What are the experiences of PSS supervised by NPS?

Theme One: Supervisor attitudes

The majority of participants reported the supervisor's attitude as an important factor in supervision. A supervisor's attitude was either experienced in a positive or negative way. Generally, if the NPS was welcoming, open-minded and able to listen, the NPS' attitude was perceived as positive. If the NPS was unable to listen, stigmatizing and patronizing, then the NPS attitude was perceived as negative. Those participants who experienced a supervisor's attitude as positive, reported feeling supported and could thrive.

Sub-theme: Respect for the peer role

A portion of the participants reported feeling respected and valued in their role as a PSS by the supervisor which was clearly conveyed by the attitude and support of the supervisor. Participants recalled instances where the supervisor demonstrated respect or spoke in ways that made them feel valued. For example, a PSS stated, "we're (she and supervisor) talking ...saying that she really hoped, I'll consider a Masters in social work, because (she said) 'I think you would be amazing in so many places.'" (S016 Other female, PSS 1-3 yrs. Satisfied, Bachelor's degree)

Other PSS felt respected when their opinions were sought:

But our supervisor is a non- peer, but they're open to suggestions. They listen to anything that … the peers have to say, and will work on it, whatever… we need and are very open ...they ask me for my advice. They …truly accept things that I can say (M028 White female, PSS over 10 years, very satisfied, bachelor's degree).

Sub-theme: Supporting autonomous functioning:

In the absence of role clarity, a respectful attitude seemed to support a supervisory approach that enabled the PSS to function autonomously. One approach

suggested the PSS create the role and functions, and share those results with the

supervisor as both learned the new role:

She's (supervisor) a clinician… she says to me, 'you know I rely on you to know what you do and I'm gonna let you make those decisions, you know … educate me!' G023 Black female, PSS 1-5 yrs., very satisfied, Bachelor's degree
She's giving me that freedom and I feel very heard by her, I wrote it (guidelines) and then gave it to her for approval, but she really studied all the different materials that I gave her about peer support and I found some guidelines online for supervising peer support and she read those. And she's given me a lot of freedom to develop a real peer support program (S041 white female, PSS 1 -3 years PSS, moderately satisfied, Associates degree).

A second, more laissez fare approach reported by a few participants also allowed

autonomous role functioning.

Since I'm pretty good at what I do, I was really given it (the freedom) to kind of make my own program, which I did and I really flourished under that kind of supervision…which was pretty much hands off. I'm given a lot of freedom here, a lot of trust. I guess you could say, and some in (the) beginning (was) so scary ...it's an incredible amount of trust in me, being the expert (R021 White male, PSS 6-9 years, satisfied, High school degree).

A third approach involved the NPS learning the PSS role by working alongside

the PSS described this way:

In my supervision, he (the supervisor said) …I'm kind of covering this (PSS) and …he was good at doing the supervision but he didn't know what we (PSS) did yet, and had to cover shifts, so during supervision, he kind of asked me … I'm going to kind of follow your lead and if you have any concerns, let me know. So that's …another reason why I say he was a good supervisor because he did ask my opinion right off the bat. And …tell me that he needed the help and so I felt really supported in that way. And I feel really supported on the team for that reason too (D017 Male Pacific Islander, PSS 1-5 yrs., very satisfied, Bachelor's degree).

Sub-theme: Non-judgmental positive communication

Communication skills that were non-judgmental, emphasizing trust, empathy and

availability, were noted as positive. Participants noted that that having supervision by an

individual who sincerely listened was key to a successful relationship with the supervisor.

The need to feel safe in supervision and have trust in the supervisor was frequently

expressed:

Somebody we can feel safe, talking to, if we are experiencing more symptoms or feel like the stress is getting to us…that's something that traditionally the folks I work with have been afraid to talk to their supervisor about because they feel like they're held to a higher standard and scrutiny, as far as like, you know, managing stress and all that kind of stuff. And relapses happen…so having a supervisor that understands that and is willing to work with you when you are experiencing more symptoms or just your stress levels getting too high (S041 White female, PSS 1 -3 years PSS, moderately satisfied, Associates degree).

We had good communication from the beginning...she's always been very willing ... open to me kind of coming into her and saying… this is what's going on with the people, these are some of the things that I feel are barriers, and she always, always gave me good feedback (T004 Indian female, PSS3-6 yrs., very satisfied, High school).

Being "heard" was talked about in the context of feeling free to share without

being negatively judged.

I've always felt like I can openly talk to her about things. It's not just like in terms of being able to seek her insight on working with individual peers in the field. It's also that I can talk to her about my own stuff (L061 White other, PSS 1-3 yrs., very satisfied, Bachelor's degree).

You know, because I wasn't able to (with a past supervisor) … be free and talk about stuff like with my current supervisor. Like I said, that's another thing… I could just speak my mind and what was said in the office stayed in office with him (D017 Pacific Islander male, PSS 1-5 yrs., very satisfied, Bachelor's degree).

Sub-theme: Perceived stigma.

The majority of participants reported feeling stigmatized. The perception of

stigma was reported on a continuum from subtle to NPS attitudes that created fear and

distrust:

Some of those supervisors that I have had were threatened by my peerness and was shocked by my abilities…underestimating my capacity to learn and grow and evolve in the workplace. And some of them were just not very nice to me and I think there were times where I felt that I was still expecting to be treated with equality. And once people

realized that I had a mental health diagnosis, I was treated with some derivative of stigma (M036 Black female, PSS over 10 yrs., very satisfied, high school degree).

This participant reported supervisory sessions perceived as continuation of patient status:

I don't know what it was, but it felt that she was treating me more like I was a consumer there rather than a worker. I felt like I was in a therapy session, rather than a supervision session. So … she would ask me questions that I would hear at my therapy session with my own therapist (J035 Hispanic male, PSS 1-5 yrs., dissatisfied, high school degree).

Theme Two: Role integration

Participants expressed the challenges in becoming a part of the mental health team: one such challenge is negotiating different perspectives:

It's (lack of acceptance) a consequence of us trying to fit into medical models that are… antithetical to how peer support actually operates because a lot of it (peer support) is based on self-help and the actual patients' rights movements of olden times, and even the anti-psychiatry movement …we push the envelope- we push people's buttons… this makes it difficult for us to be able to integrate ourselves into models that are trying to support us but ultimately can't move beyond how they view the world (L061 White other, PSS 1-3 yrs., very satisfied, bachelor's degree).

Participants experienced various ways lack of role clarity was addressed through supervision. A plurality of PSS reported experiences of the NPS being their advocate and translator of this new role to other members of the mental health team.

Sub-theme: Constructing role clarity

Most participants identified struggles with lack of role clarity. PSS reported either a lack of a formal job description, or a job description different from how they perceived their roles; or different from what they learned in peer certification training. The NPS response to this lack of role clarity was perceived as important. When the NPS was

willing to assist with role clarity, the role confusion and lack of clarity was worked

through. It was clearly preferable when the NPS was already familiar and supportive of

the PSS role. A PSS explained:

We need to have clearly defined roles …the supervisor should be someone who is very familiar with what the role entails and then someone who can speak to other therapists who are concerned that because we have mental health challenges ourselves that we might damage people. My supervisor really is championing us and is somebody who can help us with our…difficulties that we have with each other, with other staff, help us navigate (S041 white female, PSS 1-3 yrs., moderately satisfied, Associates degree).

However, if the NPS was unaware of the PSS job description, or unable to

navigate the role confusion along with the PSS, the experience was summarized this way:

 And it can really make your life miserable as a peer counselor if ...you're very new and the person can't tell you anything about your job, because they know nothing about it, or that you actually know your job really well and they won't get out of the way to let you do the job... It's maddening (J049 Asian female, PSS 1-3 yrs., dissatisfied, Master's degree).

Some participants reported being encouraged to actively define their role.

Our first supervision session was when I discovered that there was no official programming … So, I discussed that with her. I…gave her the peer support ethics and guidelines and just gave her a lot of information about what peer support actually is and what we are able to do and what we are not able to do. And she asked me if I would be willing to develop …official guidelines for our roles an …write up a new job description because the job description that they had was terrible (S041 white female, PSS 1 -3 years PSS, moderately satisfied, Associates degree).

Some of them (non-peer professionals) haven't had any experience with peers and don't know how to use them. That (meeting) was good opportunity for them to voice that and for me to, you know, kind of tell them what we do (J039 White male, PSS 5-10 yrs., moderately satisfied, Bachelor's degree).

Some NPS were open to feedback to address areas of PSS practice that were unclear.

PSS empowered by the NPS to discuss areas of conflict or confusion reported:

And that's what I'm finding what our supervision is- that when I come back with an issue that might conflict with what we do as peer and things get blurred sometimes with a peer doing one thing and you all want us to do something else. And that's not our role. I'm happy… that even though my supervisor is not a peer… she's open and she's willing to listen to what we bring to the table and that's been awesome experience so far (G023 Black female, PSS 1-5 yrs., very satisfied, Bachelor's degree).

As role innovators, some PSS struggled with the possible meaning of a lack of

role clarity as expressed in the following way:

But their understanding of the peer support role should never fall solely on the shoulders of us… because that's going to be what is happening 90% of time and it's almost devastating, it's really disheartening to us that ... we're put in a position where then we have to explain or prove our worth to individuals who are supposed to be supporting us. And it almost feels like they're questioning us in ways that (they) shouldn't like we shouldn't have to do that (prove our worth) at all. It feels divisive and there's … a power differential there that really shouldn't be (C044 White female, PSS 1-5 yrs., dissatisfied, Associates' degree).

Some participants interpreted a lack of a formal job description or assigned tasks

outside their understanding of their peer role as demeaning. A PSS noted:

Are we really able to do real work? because they're (supervisors) just used to saying, "oh, they need to be hospitalized right now," so…they don't think that we're intelligent enough to do anything other to make photocopies (C026 Black PSS 5-10 yrs., dissatisfied, High school degree).

Sub-theme: Role adaptation

Role adaptation refers to those opportunities created by supervisors, for example,

attendance at team meetings, that allows PSS to understand the full context in which their

work occurs. PSS stated such an understanding gave them a chance to adapt how they

prioritized information, for example, which in turn presented their role in ways that built

understanding between PSS and licensed professionals. It also gave PSS an opportunity

to explain their roles in a manner helpful to their respective team. A PSS expressed:

It's interesting. The difference in thinking, … I think that's really one of our opportunities to shine with difficult patients because we're able to flex that creativity that helps make us solution oriented and yeah, sometimes it's just perspective, having somebody else's sight on stuff but being there (team meetings) and getting to hear the way that those professionals are interacting was an incredible takeaway for me…The other side of that and knowing having a glimpse of their world, I think has helped …me (be) more effective in encounters with them. So…if I present a case… I could do it in a way that leads with the stuff they're interested in hearing…what they need out of it and it makes them a lot more receptive to the things that I want them to know about the person (J039 White male, PSS 5-10 yrs., moderately satisfied, Bachelor's degree).

Sub-theme: The challenge of maintaining practice boundaries.

Participants expressed confusion about addressing relationship boundaries cited in agency policies. For example, PSS reported that such policies reflect a different stance to interaction with service users than those with which they were familiar with. Participants looked to NPS for help navigating these boundary policies as indicated by one participant:

Just kind of being more aware of the struggles and, you know, making sure that the supervisor understands what a peer support does in the field. Um, how difficult, it can be holding boundaries. Being understanding of that where we want to reach out and help you know these clients that we're working with in in a variety of different ways, but understanding, you know, that is where we come from (R037 White female, PSS 6-9 yrs., very satisfied, High school degree).

The NPS was an important partner for the PSS as the difference in practice boundaries were negotiated.

Everybody needs supervision doing this type of work to make sure …, because sometimes I might want to go do something that's kind of on the edge. Maybe I shouldn't give out my phone number to people, which I do occasionally, but I don't do, generally as a rule (D017, Pacific Islander male, PSS 1-5 yrs., very satisfied, Bachelor's degree).

Theme Three: Trauma informed supervisory techniques

Participants expressed that supervisors needed to be aware of the toll their work took on them due to their constant use of self and their often-deep sharing of lived

experiences when working with peers. Three sub-themes captured the components of trauma sensitive supervision: encouraging self-care, recognizing compassion fatigue or moral injury, and preventing retraumatization.

Sub-theme: Encouraging self-care

The majority of participants welcomed a supervisor's concern about them as a whole person. Questions from NPS about their mental and physical health appeared to be expected and interpreted as recognition that their needs for support on the job were different from non-peer colleagues. NPS who communicated sensitivity without judgement seemed well received:

And peer support supervisors should understand that we, as peer supports have got our own problems. That's why we're here. So, we have a unique set of circumstances that all other employees don't have. So, we, we need somebody that is compassionate and understanding. Somebody we can trust (R021White male, PSS6-9 yrs., satisfied, high school degree).

So, the boss is really understanding…very supportive of our mental health needs which was very memorable and helpful… was able to discuss my mental health challenges openly with my supervisor and not feel judged or made to feel like I was making excuses for stuff or that I was lazy. The stigma wasn't attached to it… (J046 White female, PSS 3-6 years, moderately satisfied, Bachelor's degree).

Sub-theme: Recognizing compassion fatigue and moral injury

Participants reported it was critical for NPS to recognize that compassion fatigue may occur quickly in PSS, as a result of their own status and identification with the people they serve. Participants noted supervision was helpful, when there was early recognition of compassion fatigue. Support and frequent debriefing were considered essential:

I think the support the peers need- I think it's really important. I think the field can be very draining and compassion fatigue (happens). It happens real (sic) fast! J046 White female, PSS 3-6 years, moderately satisfied, Bachelor's degree

    Participants noted the value of regular opportunities to debrief.

That supervision time and being able to have that good discussion is important. It's crucial because I think I would find myself getting into that empathy burnout. Because I would still think about them (clients), I would still go, Hmm, I wonder how they're doing? Or I wonder how this situation was or how that turned out. And I don't think I'd ever be able to shut that off, if I didn't have that supervision piece of that, to have someone to talk through it would affect me very negatively in that that I would just never let those things go. I would constantly be in that cycle of thinking about it and then I would burn myself out (T004 Indian female, PSS 3-6 yrs., very satisfied, High school).

    Equally important was the NPS ability to allow the PSS to determine personal

limits:

I can tell them… I have too many (cases) and they listen to me. So, I'm not even afraid to say …I'm overloaded right now. I cannot take on any more people and they don't say, oh, but yes, you can. You know they just say, okay, like, you know what you can do and what you can't do, which I think is great because where I worked previously, it wasn't like that it would just keep adding on, adding on until you were kind of like overdone, you know, burned out (M028 White female, PSS over 10 years, very satisfied, Bachelor's degree).

    Moral injury is an experience associated with peer work reported by participants.

Participants noted witnessing situations that were unacceptable to them as peers;

situations where they felt anger and helpless to intervene on behalf of a service user:

Yeah, people get burned out, and they have compassion fatigue. But I think it's also not just compassion fatigue… there's so much burnout that happens from moral injury that happens like in the work that we see… they suffer moral injury, more so than compassion fatigue…Maybe I could be kind of jaded in that viewpoint…like I just feel here in this climate and this system that 80% of the time when somebody is burned out, it's a moral injury of injustice with the system versus the compassion fatigue of watching somebody struggle (C044 White female. PSS 1-5 years, dissatisfied, Associates degree).

I think it's especially harder for somebody that has their own mental health struggles, and I think making sure that when there is like a crises or secondary trauma or something going on…making sure that that support from the supervisor is available. I think that is really, really crucial. There was times that I felt like, okay, I'm doing something like kicking someone outside at five o'clock because we're closing the doors and they're

homeless and have nowhere to go but I can't let them stay here and I have to sit there and kick them out the door and close the door. And now what do I do with that? Yeah, that was extremely hard and I had nowhere to go with that (J046 White female, PSS 3-6 years, moderately satisfied, Bachelor's degree).

Sub-theme: Prevention of re-traumatization

Many participants spoke about the need for NPS to recognize situations that may be

retraumatizing for PSS. Often participants encounter situations on the job that remind

them of traumatizing situations they experienced as a service user, for example like team

discussions about involuntary hospitalizations which may trigger a painful memory.

I remember…this is my supervisor…. he is very, very supportive and going through that … listen to me, let me go through the things that I was going through and the feelings that it caused cuz …I got some PTSD from the past and stuff. And it kind of flared that up a little bit …he just talked me through it and …I mean he's not a peer supervisor… just feel overwhelmed or whatever, having a safe place to be able to go talk...let some stuff out in a safe environment.…just so that I can continue to do my job and stuff through these situations (D017 Pacific Islander male, PSS 1-5 years, very satisfied, Bachelor's degree).

PSS expressed the importance of NPS not only recognize that PSS can be

retraumatized during the normal course of their work, but also that triggers are very

individual and not always recognized by the person experiencing retraumatization:

We're going into situations where we could be triggered. And I think the clinicians are trying to be… I see that … the majority of them are trying to be sensitive to that and at the same time, if they do not have their own lived experience, they don't understand that. They're coming from their clinical experience and they actually have a much more protected environment, working with individuals than we do, where they have you know a controlled environment in their clinical office. They have certain guidelines and frameworks that they have to work within and around. They have their own set of rules as do we, however, ours is just more open to, so to speak, where we go into individual homes. We're working with them in the community, we're faced in different physical environments that could put us at risk to the way that people act, so we see things more, we are exposed to more and we're already a high-risk vulnerable population so that needs to be addressed. when we are inevitably faced with something that could be triggering to us- we have the understanding and support of our supervisors that know what we are facing, know who we are as individuals and what our triggers are and how they can be

supportive to us and what we need to navigate those potentially hot crisis and dangerous situations (C044 White female, PSS 1-5 years, dissatisfied, Associates degree).

Sub-question: How do PSS perceive the influence of non-peer supervision on their work?

These next two themes reflected how PSS experienced the influence of supervision.

Theme Four: Facilitative/supportive environment

Many participants credited supervision for allowing them to grow personally and professionally. Through advocacy and ongoing support, the NPS helped create an environment that allowed the PSS to gain confidence in themselves and their skills:

And he was really great about allowing me to flourish in my role, to grow in my role, and I would take on things and share them with him, my ideas and agendas and he supported me through everything… able to invite me to expand my version of myself and tap into resources and skills that I didn't even know I have (M030 White female, PSS 5-10 years, moderately satisfied, Associates degree).

She is a licensed social worker, but she actually works with kind of a peer support ethic. She's very person centered… really an inspiration to me and so, I've gone on calls with her…to shadow her to see how she does what she does, and her ability to connect with people has taught me a lot (S041 White female, PSS 1 -3 years PSS, moderately satisfied, Associates degree).

I have gained some good understanding of concepts and I have felt validated in some ways from their clinical perspective… was very helpful because it felt they were investing their time into me like they believed in my role (C044 White female, PSS 1-5 years, dissatisfied, Associates degree).

Theme Five: Perspective taking

For some participants, the PSS job was their first employment opportunity. The NPS was perceived as critical in successful adaptation to agency policies and procedures.

Lived experience or PSS training does not necessarily prepare a PSS for procedures such

as, time and attendance policies, record keeping, or team goal-setting:

Supervision at the beginning of my practice was extremely helpful because I was still
green in working in a professional setting (L061 White other, PSS 1-3 yrs., very satisfied,
Bachelor's degree).

It influenced my work by setting the standard and being mindful of the ethical nature of
my work and also being also towing the line as far as what the VA. requires of its normal
workforce (K033 White male, PSS over 10 years, moderately satisfied, Bachelor's
degree).

The opportunity to understand the clinical view of the work gave participants

exposure to multiple administrative policies and procedures or clinical perspectives that

would not have been either a part of their lived experience or their peer certification

training. For example, challenges in creating billable hours, record keeping, and

managing HIPPA were a predominant concern:

If there's any question whatsoever about my job, anything related to where I
question whether I'm …doing the right thing. I'll always go to her. So there's been several
instances where I had a question about how something should be done like paperwork
and making sure to make sure that HIPPA is not violated, a lot of instances with that
because, you know, I want to make sure that I don't do something (wrong) on my end
(R037 White female, PSS 6-9 years, very satisfied, high school degree).

The NPS was seen as important as a guide to the work setting's norms and culture

and perhaps, more importantly, to the informal rules and regulations:

It taught me about the system and what clinicians' value. I mean, just this is going to
sound horrible but like it's taught me how to talk the language better.to...I mean, in some
ways, it's taught me how to hide, how to know what to hide, what to be open about. And
to me it wasn't obvious when I was first hired, which are the policies that are real policies
that you have to follow or you'll get fired and which is the policies that they really want
you to follow. You'll get in trouble, but you won't be fired if you don't follow and which
are the policies that are literally impossible to follow (J049 Asian female, PSS 1-3 yrs.,
dissatisfied, Master's degree).

Many participants reported that supervision with NPS gave them an opportunity to

understand the differences in perspective:

The other side of that and knowing having a glimpse of their world, I think …has really helped me, (be) more effective in encounters with them. Um, so they have a difference…But we're all about, self -disclosure…it's part of the job, it is the expectation that you're going to come in and you're going to share some of your worst days with people. And they (non-peers) are taught, you know drilled almost to not do that at all. And so, it's very confusing to each group (J039 White male, PSS 5-10 yrs., moderately satisfied, Bachelor's degree).

Sub-question: What do PSS think the role of supervision is in providing peer support services?

Responses to this question contained similarities to traditional supervisory roles,

for example, administrator, educator and supporter functions (Kavanagh et al., (2002).

But, two themes emerged suggesting there are additional distinct roles for NPS.

Theme Six: Opportunities for PSS interaction

Every participant suggested a peer supervisor would be invaluable to them so

they could learn from and report to others doing the same work:

The best supervision is a partnership…is… someone who's done the work for a long time and has lived experience as a peer counselor., so that they can mentor and coach you into being a better peer counselor. It's pretty hard, because I think sometimes clinical work and peer counseling are sometimes at odds because they have different goals and different methods (J049 Asian female, PSS 1-3 yrs., dissatisfied, Master's degree).

They also expressed hope that a PSS in a position of authority could advocate for

them on issues of low pay and lack of a career ladder:

If peer support is going to be a part of traditional agencies, they need to be their own department. They need to be self-run. The head of those departments, needs to be a peer and they if they are going to, … be implemented into that hierarchy, then yes, that does mean that they need to be in one of those higher rungs of authority because that's where

they're able to most effectively advocate for the folks on the lower rung of the ladder (L061 White other, PSS 1-3 yes, very satisfied, Bachelor's degree).

The majority of participants suggested that in the absence of a peer supervisor, networking with other PSS was important. PSS expressed the desire that the supervisor would create opportunities or support self-initiated opportunities for PSS to meet with other PSS. Providing access to conferences and trainings was viewed as the role of the supervisor. Conferences and trainings gave PSS additional opportunities to learn from other PSS. Participants experienced a variety of ways a need to network with colleagues was being met. For example, some NPS met with the PSS as a group thus allowing mutual learning and problem solving:

At least there was a group supervision every week. And so, we could like collaborate with the other peer workers that were there and kind of glean some insight (C044 White female, PSS 1-5 years, dissatisfied, Associates degree).

Other NPS appointed a more experienced PSS to informally supervise the other PSS:

About a year and a half ago, (the agency) asked for a peer mentor …she (supervisor) thought of me to do it. And what that entails is that I have a meeting monthly with all my peer support specialists, even though she's head of everything (R037 White female, PSS 6-9 yrs., Very satisfied, High School degree).

In some agencies, PSS networked among themselves:

In fact, (there have) been situations where I needed to figure something out in terms of how to support somebody and I would talk to the other peers in my office … because they would know what I should do right or just how exactly it is that I can process this stuff so that I can figure out what it is that I need to do (L061 White other, PSS 1-3 yes, very satisfied, Bachelor's degree).

I think it's very difficult when you have someone who's really knows nothing about peer support as most of our supervisors don't and then for them to understand the differences and how we work a lot of people are very nervous about sharing our personal stories.

And… feel like we're going to traumatize people or there's just a lot of …just uncertainty around, you know how stable is she really, you know, So, I think that a lot of the other peer support staff will come to me when they're having issues with their supervisor, even though I'm not their supervisor… and we'll talk through it (S041 White female, PSS 1 -3 years PSS, moderately satisfied, Associates degree).

Theme Seven: Mutual learning

Participants expressed a desire to eliminate the power differential in supervision.

Instead they spoke of supervision as a mutual experience of the PSS and NPS learning

from one another:

That (mutual learning relationship) would …allow the building of a relationship that's not based on power, is based on the role and the duties of the work and the skills that needs to happen on both sides (M036 Black female, PSS over 10 yrs., very satisfied, high school degree).

So, having that supervisor to, you know, this is what we're doing. I'm working with this person. These are some struggles. I'm having these are some successes I'm having and getting that (discussion) both ways, because we learn from one another (D015 White male, PSS 3-6 yrs., moderately satisfied, Bachelor's degree).

Theme Eight: Preference for a supervisor with experience as a PSS.

The majority of participants stated they wanted a supervisor who had experience

working as a PSS as noted:

She (NPS) sees the value in having a peer support supervisor for the peer support staff. I think it's very difficult when you have someone who's really knows nothing about peer support as most of our supervisors don't (S041 white female, PSS 1-3 yrs., moderately satisfied, Associates degree).

Summary

Findings suggest that supervisory functions can be enhanced by additional efforts

specific to the needs of PSS. In certain ways, the experiences of PSS supervised by NPS

shared similarities to general reports of effective or ineffective supervision. Participants

identified multiple positive NPS' qualities such as good people skills, ability to listen, open minded, flexible, and supportive. Those participants reporting negative experiences mentioned a supervisor's lack of people skills, authoritarianism, inability to listen, focus on peer status and unavailability. They often reported feeling devalued and misunderstood. More importantly, their experiences clearly suggest additional supervisory skills are needed, specifically those addressing: supervisors' attitudes, role integration, and trauma-informed supervisory techniques.

A supervisor's attitude was critical and foundational to PSS success. Those participants who experienced a supervisor's attitude as positive, reported feeling supported and could thrive. A positive NPS attitude included respect for the peer role, positive nonjudgmental communication and support for autonomous functioning. Even if the NPS did not fully understand the peer role, an attitude of respect supported the ability to form a supervisory relationship with the PSS. And, perhaps, positive non-judgmental communication was often mentioned because it happened in the context of the prevalence of perceived stigma. Autonomous functioning was an interesting finding. In the absence of role clarity, a respectful attitude seemed to support a supervisory approach that enabled the PSS to function autonomously. In general supervisors who are supervising within an explicit practice domain understand the general functioning of their supervisee. In the case of a PSS supervised by an NPS, that intimate understanding is missing. But when supervisors acknowledged their own lack of understanding and supported autonomous functioning anyway, a supervisory relationship within which to discuss the role was created.

Role integration is at best incomplete and remains a barrier to PSS success. Participants expressed the challenges in becoming a part of the mental health team because of the differences between PSS and non-peer values, skills and perspectives. The NPS was an important part of rectifying lack of role clarity, negotiating challenges with practice boundaries, and supporting role adaptation.

Trauma informed supervisory techniques are important aspects of PSS supervision. Participants expressed that their use of self, their sharing of lived experiences in working with others, required supervisors to be aware of the toll their work took on them. Trauma informed supervisory techniques require an emphasis on self-care, acceptance of early compassion fatigue, and/or moral injury and prevention of re-traumatization.

The influence of supervision by an NPS was associated with two areas: it was an important factor in establishing a facilitative/supportive environment, and perspective taking. Participants were influenced in supervision to recognize their own strengths and weakness. They were also influenced to begin to understand the point of view of non-peer professionals. Participants identified two major roles of supervision. The first role was to create opportunities for PSS interaction. Group supervision was found helpful when it provided a chance for PSS to learn from one another. Providing access to conferences and trainings was viewed as the role of the supervisor. Conferences and trainings gave PSS additional opportunities to learn from other PSS. The second role identified by participants was one of mutual learning, eliminating the power differential between expert and novice. Finally, PSS stated a unanimous preference for a supervisor with experience as a PSS.

The themes that emerged from the data align with some of the consensus opinions expressed in The Pillars of Peer Support: Peer Supervision (Daniels et al., 2015). For example, the consensus that PSS supervisors understand and support the role of the peer specialist relates to the themes of role integration and supervisor attitudes. The theme of trauma informed supervisory techniques aligns with the suggestion that PSS supervisors support the personal growth of the PSS. The next chapter will discuss this further.

The next chapter provides a discussion of these findings, limitations of the research, implications for practice and suggestions for future research.

Chapter V

Discussion

This study explored the experiences of PSS supervised by NPS in adult community mental health settings. Since the 1990's, community mental health settings have been transitioning from a medical model of treatment to a recovery-oriented model (Anthony, 1993; Ashcraft & Anthony, 2009; Dalum, Pedersen, Cunningham, & Eplov, 2015; The President's New Freedom Commission, 2003). In contrast to the medical model, the recovery approach supports collaborative partnerships and autonomy in decision making for people with mental illnesses. PSS represent a recovery-oriented approach and in so doing, exemplify efforts by mental health settings to move away from a medical model to a recovery-oriented perspective. It is within a changing culture marked by differences in perspective and values between non-peer professionals and service users that PSS do their work.

Participants in this study reported barriers and challenges to integration into traditional mental health settings including disbelief of personal recovery, discrimination, demands of provider responsibility, limited educational options, lack of role clarity, role confusion and competition, unrealistic job demands, and attitudinal barriers. These are similar to the integration barriers and challenges noted in prior literature (Ahmed et al., 2014; Ashcroft & Anthony, 2012; Bennetts et al., 2011; Cleary et al., 2011; Garrison, Ackerman, & Forest, 2010; Moran et al., 2013).

In some cases, these integration problems arise from the experiential and role mismatches between PSS and NPS. Recovery values of equality, social inclusion and

connectedness are not always operationalized even in agencies that identify as recovery

oriented (Glajz, Deane, & Williams, 2017). A study by Byrne, Happell and Reid-Searl

(2016) found that the culture of the prevailing medical model posed limitations on

implementation, effectiveness and development of the peer role. Research by Bennetts et

al., (2011) suggests that those who hold power, such as non-peer professionals, are

reluctant to share power and in not sharing frequently restrict PSS ability to impact

services or effect change.

Literature cited previously has argued that supervision is an answer to these

challenges. Medicaid requires supervision by a competent mental health professional as

defined by individual states. There is not specific empirical data that offers a theory on

peer supervision within which to place this study. In the absence of such a theory, this

study uses The Pillars of Peer Support: Peer Specialist Supervision (The Pillars) (Daniels

et al., 2015) as a consensus statement. The Pillars developed recommendations built

through a fairly rigorous consensus process. These broad recommendations were offered

as technical assistance to states. Some of these findings illustrate how these

recommendations are being operationalized in the workplace.

The four major findings of this study support the argument that supervision

between a PSS and NPS can result in communication difficulties. As previously noted by

Bellamy, Schmutte and Davidson (2017), there are differences in understanding between

lived experience and academic credentialing. Although acceptance continues to grow,

professionals still seem skeptical about the value of peer support. PSS and non-peer

professionals hold differing beliefs and concepts about what is valuable and effective in

treatment (Aston & Coffey, 2014; Kogstad, Ekeland, & Hummelvoll, 2011). Recent

research suggests that some professionals convey the message that lived experience is not

relevant (Mulvale et al.,2019). Gordon and Ellis (2013) argue that the recovery approach

and the medical model approach are philosophically in opposition and perhaps cannot be

employed at the same time with much success. The results of this study support the

assertion that NPS and PSS are currently negotiating these differences in the workplace.

For example, role clarity is contextual and is best operationalized on the job. Within a

facilitative/supportive environment and with the advocacy of the NPS, PSS are achieving

greater role clarity and a measure of role integration. Practice boundaries that differ in so

many ways from a PSS and NPS are also getting clarified.

The first important finding was that the NPS attitude toward the PSS is a critical

factor. This finding is in alignment with the recommendation from the Pillars (Daniels et

al., 2015) that the supervisors be trained in quality supervisory skills. One could argue

that an attitude of respect as well as the ability to communicate in a positive manner are

quality supervisory skills. A positive NPS attitude includes respect for the peer role,

positive nonjudgmental communication and support for autonomous functioning. Respect

for the peer role is foundational. The PSS role simultaneously represents a recovery

orientation, lived experience, and a departure from sole reliance on academically trained

professionals. PSS act as role models for service users. Respect for the peer role

acknowledges that lived experience is different from academic experience, relinquishes

the inherent power differential supported by the medical model, and supports an open

minded, curious approach to service users and their problems. Even if the NPS does not

fully understand the peer role, an attitude of respect supports the ability to form a

supervisory relationship with the PSS. Based on my findings, my initial perspective/bias

of years of watching these interactions, was that peers would not like their supervisors

but this is clearly not the case. In most of the interviews, peers reported liking their NPS

and reflected genuine appreciation for the supervisor but what was confirmed is that

supervisors have a wide variation of skills when providing peer support.

It is true that any supervisee wants to be treated with respect. The importance of

this attitude for PSS is in part a consequence of the lack of fit between NPS and PSS

views and expectations. The PSS is often a role innovator: A role innovator integrating

into a treatment system that may have disparaging elements. PSS are accustomed to

stigmatizing attitudes from others, even non-peer professional staff. The President's New

Freedom initiative (2003) prioritized the need to address stigma and its debilitating

impact. This study's findings support research suggesting that stigma still impacts PSS in

the workplace. These findings also support research that suggests stigma does not end

with PSS employment (Kemp & Henderson, 2012; Nestor & Galletly, 2008; Moran et al.,

2013; Vanderwalle et al., 2016; Waynor & Pratt, 2012). Stigma impacts the life and

opportunities of service users and PSS (Amsalem, Gothelf, Hasson-Ohayon, & Roe,

2018; Thornicroft, Rose, Kassaam, & Sartorius, 2007). Some PSS, reflecting recent

findings by Amsalem, Gothelf, Hasson-Ohayon, and Roe (2018), reported feeling like

second class citizens: Invalidated and viewed as inferior. If the NPS attitude is perceived

as stigmatizing, it can lead to an unsuccessful supervisory relationship, failure of role

integration, or possible lack of job retention. NPS who demonstrate respect create an environment where other barriers to PSS acceptance can get addressed.

An effective supervisor's attitude includes the willingness to communicate in a positive, nonjudgmental manner. Respect for the peer role and positive, non-judgmental communication work interdependently. It may seem contradictory, but NPS may exhibit positive, non-judgmental communication but at the same time may not agree with the peer role or respect it. On the one hand, positive, nonjudgmental communication without respect for the peer role can result in supervision seeking to align the PSS with academic experience and the medical model. It can result in co-optation as the PSS attempts to express the peer role in ways that the NPS suggests. On the other hand, an attitude of respect for the peer role without positive nonjudgmental communication can result in the NPS inability to communicate effectively to the PSS and others, acceptance, value and support for the peer role. Positive nonjudgmental communication, perhaps important for all effective supervision, is particularly important in combination with respect for the peer role, as it acts as a buffer against the perceived stigma the majority of PSS reported in the workplace.

The second important finding, and likely related to the lack of effective supervision, was that PSS continue to experience poor role integration. This theme connects to the recommendation from the Pillars (Daniels et al., 2015) that the supervisor should understand and support the role of the peer specialist. As noted by Gates and Akabas (2007) role integration failure is a barrier to PSS success. Despite over a decade

of funding for peer roles, integration of the PSS role in the workplace remains incomplete.

There are several reasons this lack of role clarity continues. The major reason is the role of the PSS represents a change to traditional ways of thinking and practice. Another reason is the newness of the role. Incorporating a new role in an existing culture takes, effort, time, and patience. In this case improving role integration requires addressing a lack of role clarity and differences in practice boundaries. A recent study by Gillard et al., (2014) recognized that practice boundaries were important in a variety of work settings. However, practice boundaries are understood and employed differently depending on the setting. Such variances in practice add to the PSS struggle with putting practices that vary from setting to setting into practice.

Successful role integration requires the use of role adaptation. In this instance, role adaptation is the ability to prioritize knowledge to meet the goals expressed by non-peer colleagues on the treatment team. As several PSS explained, once they had a better idea of the team's priorities, they could offer information that might not seem as important from a peer's point of view but more readily met team goals. One PSS indicated, for example, adapting how you see the role as offering knowledge of existing community supports rather than focusing on representing the expressed treatment needs of the service user that may be in conflict with the treatment teams' recommendations. Even the best articulated job description gets operationalized on the job in concert with a supervisor. But, an NPS cannot easily provide comprehensive guidance for a job they have never done.

The third important finding was the necessity of employing trauma informed supervisory techniques. The Pillars (Daniels et al., 2015) recommended that the supervisor should promote both the professional and personal growth of the PSS. One of the elements of personal growth is recognition and support provided by trauma informed supervisory techniques. Participants spoke about a need for debriefing with an NPS when encountering situations on the job that represented previous traumatic events. It was not suggested that the NPS take the place of a therapist for treating trauma, but rather to recognize that the PSS use of self could expose them to work-related triggers. Trauma informed supervisory techniques with an emphasis on self-care, acceptance of early compassion fatigue, and/or moral injury and prevention of re-traumatization are necessary for PSS to do their job. Trauma is strongly associated with persons diagnosed with a mental illness (Álvarez, Roura, Osés, Foguet, Solà, & Arrufat, 2011; Meuser, et al., 1998). A possible explanation is that the PSS use of self is different from the non-peer professional use of self. In the context of PSS self-disclosure, empathy can take on a different, even more personal meaning. Reliving difficult experiences could trigger shame and reinforce internalized stigma. It could also be that this finding suggests a vulnerability in this particular workforce that is difficult to separate from their use of lived experience. Mental illness is often considered a "stress vulnerable" disease. It is possible that vulnerability to stress causes greater experiences of compassion fatigue or burn out, i.e. emotional and physical exhaustion. Regardless of origin, the constant possibility of such triggers requires an emphasis on employing trauma informed supervisory techniques. The literature mentions supervision as a counterbalance to

compassion fatigue (Merriman, 2015). However, the sporadic nature of supervision coupled with high turnover of supervisors offered less opportunities to talk through cases and interactions with service users. Beyond compassion fatigue, some PSS are facing possible moral injury in the workplace. According to Drescher et al. (2011), moral injury "is a construct proposed to describe disruption in an individual's sense of personal morality and capacity to behave in a just manner." PSS have, in all likelihood, experienced difficult situations within the mental health system that just felt "wrong" to them. For the NPS, response to difficult situations may be a matter of following policy and procedures; for PSS the response may be accompanied by memories from lived experience.

The findings in response to sub questions on influence and supervisory role are supportive of the four major findings. They point to the differences between experiential and academic experience. They also underscore the Pillars (Daniel et al., 2014) recommendation for particular attention to the professional growth of the PSS. PSS saw the role of the NPS as someone who could create opportunities for interaction with other PSS. One explanation is that in many ways, such interactions serve as a substitute for supervision by a more experienced PSS. PSS cannot directly learn the PSS role from an NPS or non-peer colleagues. NPS cannot role model a job they have never done.

Happell and Roper (2009) suggest that lack of collaboration between mental health professionals leads to isolation. In many cases, PSS work as the lone PSS on a clinical team decreasing opportunities for discussion and collaboration with others doing similar work. Opportunities for interaction with other PSS would decrease the possible

isolation PSS feel. Social comparison theory suggests when individuals find similarities

between themselves and others it helps them better understand their own situations (Tse

et al., 2017). Interaction is also a process by which individuals form a sense of identity

within a group of others who are similar to them. Interactions with other PSS offer

opportunities for PSS to further define their role, to learn from others, to support one

another and to decrease a sense of isolation.

Another finding was that the role of the NPS was to join in mutual learning. For

the PSS, desire for mutual learning represented a supervisory relationship less defined by

a power differential and better defined as a partnership. The recovery approach supports

collaborative partnerships and autonomy in decision making (Gordon & Ellis, 2013).

This finding suggests that PSS view supervision as an opportunity to promote peer values

such as mutuality and partnership. Mutual learning can be understood to bridge the

differences in values and perspective between those with lived experience and those with

academic credentials. Peer values prioritize partnership over relationships with an

inherent power differential. The peer approach of mutuality accepts that partners in a

supervisory relationship bring equally valid but perhaps different perspectives.

PSS cited the influence of NPS on their ability to participate in perspective-

taking; using any and all opportunities to understand the perspective of non-peer

colleagues as well as the broader agency goals. Perspective-taking supported role

integration serves to highlight not only the different world view brought to the workplace

by PSS, but the common goal of wanting to help services users. Mulvale et al., (2019)

found that activities that promoted contact between staff and PSS resulted in

opportunities where both parties clarified their roles. Recent research suggests that over time co-workers move from confusion about the peer role to view PSS as an asset (Tse et al., 2017). Both PSS and non-peer colleagues use perspective taking to understand how the peer role fits into an established culture and contributes to helping service users.

The influence of NPS creating a facilitative/supportive work environment was identified as important to PSS. This highlights the PSS perception of the differences in the workplace they represent. Whether or not PSS intend to be role innovators, the role they occupy is relatively new so that PSS frequently felt isolated and at odds with the existing culture. Their differences in values and approach require an environment that is open to such changes and an NPS that is supportive.

Finally, an important finding is that PSS want to be supervised by an experienced PSS (i.e., someone who has actually done the job), has not been previously documented. As noted by Bernard and Goodyear (2004), the purpose of supervision is for a senior member of a profession to role model practice behaviors for a junior member of that same profession. Another study suggests supervision advances professional and personal development in a supportive relationship among equals (Butterworth, Bishop, & Carson, 1996).

NPS rarely have lived experience and in all likelihood do not know how to model such behaviors. Another way to look at this finding is to understand that the integration of the peer role within the service system is a relatively new task. Neither the PSS nor the NPS have had years of experience on which to model PSS work or supervision. Although unanimously suggested, supervision of PSS by experienced PSS, is generally unavailable.

Limitations

Factors relating to sampling and data collection procedures contributed to study limitations. First, the participants were self-selected to the extent that they responded to the survey. Second, all participants were recruited from iNAPS. The characteristics of these participants may represent a different sphere of experiences, or values from PSS who are not members of iNAPS or who are members of other peer organizations. Again, they may not be representative of the population under study. We don't know the supervisory experiences of those no longer in the workplace. The PSS in this study have remained in the workforce and therefore likely represent a population that has had at least a modicum of success in the field and possibly better supervisory experiences than those who have left the field. Fourth, although all participants stated they had the same supervisor for 12 months or a minimum of 12 sessions, many participants also had multiple supervisors. Supervision was irregular with very few participants reporting regularly scheduled supervision. However, the lack of consistency of supervision or supervisors created a composite of memorable experiences. Fifth, identifying the amount of experience of the supervisor could have contributed important data with which to understand PSS experiences. Sixth, the researcher was the tool for data collection and analysis and thus subject to inherent bias. The impact of the researcher's background and experience on data collection and data analysis are limitations of research procedures. Finally, a lack of other qualitative studies makes it impossible to compare other findings to this study. Given limited time and resources, this study did not expand interviews to include the people responsible for Pillars to understand their experiences.

Multiple efforts to increase trustworthiness and to minimize researcher bias were incorporated into this study, such as maintaining reflexivity by memoing and journaling, data analysis triangulation, peer debriefing and member checks (Birt, Scott, Cavers, Campbell, & Walter, 2016; Braun & Clarke, 2006). To ensure the accuracy of analysis, the use of peer debriefing and data analysis triangulation represents another strength of this study as such regular discussions with other qualified researchers can minimize bias.

Implications

Supervision of PSS require additional functions different from those associated with clinical supervision. NPS need to recognize the differences in values and practices that PSS bring to the workplace. Supervision can be an important component of successful integration. Supervisory practices, specific to PSS need to be included in supervisory training. Effective training for NPS needs to include emphasis on values and practice differences.

Achieving role clarity is a joint effort. As suggested by Gates, Mandiberg and Akabas (2010), education of professional staff, organizational changes and ongoing feedback from PSS can support efforts at integration. Integration relies on a total agency plan to hire, orient and support PSS. Role clarity is contextual. Agencies can do a better job designing job descriptions and offering peer specific orientations.

Although clinical supervision is a familiar tool within mental health settings, future trainings can emphasize challenges inherent when supervising someone from a different profession. Sensitivity training can be a tool to address stigmatizing attitudes. Data does not yet exist on the retention rate of PSS, but anecdotal evidence suggests that

lack of job retention is a significant barrier to maintaining a robust peer workforce. NPS who can include in their supervision support for self-care; offer de-briefing for the ever-present threat of compassion fatigue or moral injury; and be available to discuss the possibility of retraumatization will in all likelihood create an environment where PSS may succeed.

The majority of participants in this study argued for peer supervision of PSS. In a situation where PSS were supervised solely by a peer supervisor might the peer workforce become ghettoized in some settings, reducing role integration and losing some of the other benefits PSS bring to the regular work force? Recovery values of equality, social inclusion and connectedness are not always operationalized even in agencies that identify as recovery oriented (Glajz, Deane & Williams, 2017). Although this study did not seek to correlate recovery orientation with PSS experiences, one might predict that a peer supervisor is more likely to embody those values. The importance of having someone understand the PSS role because they themselves are doing it, cannot be underestimated. It is unlikely that NPS have had the experiences necessary to role model lived experience. Additionally, while the NPS may understand the role of the peer, they are unlikely to have direct experience performing those tasks. PSS have needs not generally associated with clinical supervision, like providing assistance with role integration and practice boundaries, advocating for a supportive/facilitative environment for PSS who are introducing new practices and providing trauma informed supervisory techniques.

Many PSS work for minimum wages without a career ladder. The creation of a peer supervisor title would encourage the beginning of a possible career ladder. States could consider offering certification or licensure of peer supervisors as a possible step towards creating peer supervisors. A peer supervisor would also then be in a position in the administrative hierarchy to advocate PSS to have salary increases and opportunities.

Peers expressed that a vital role of supervision is to ensure the opportunities to create and belong to networks within the workplace. Access to peer trainings was suggested as one way to create networking; the creation of a peer network which sustains PSS before, during, and between employment is another. Although there are national networks like iNAPS, a network that supports PSS wherever they work would be helpful as suggested by social comparison theory (Tse et al., 2017).

Future Research

More studies of PSS supervision and its impact on PSS practice are needed. As a first step, this study found PSS have different supervisory needs. Role integration takes place over time with support and advocacy. Future studies need to identify how and under what conditions role clarity is achieved. Gates, Mandiberg, and Akabas (2006) made recommendations for successful peer integration into the workplace. Replication studies may provide additional information for agencies to follow to improve peer integration strategies.

The President's New Freedom Commission (2003) prioritized the need to address stigma and its debilitating impact. This study suggests that focused research on efforts to

eliminate stigma within the workplace context and PSS-NPS supervisory relationship could make an important contribution.

The mental health field has made important strides in its efforts to recognize and understand trauma in service users. Some service users are now employees. Much is known about the impact of compassion fatigue on front line service providers. However, research on the differences in compassion fatigue between non-peer professionals and PSS could be important in identifying different precursors.

The NPS attitude towards the PSS role was crucial in either its success or failure. How supervisors are assigned is an important area of interest. Future research could identify supervisory characteristics that correlate with positive PSS supervision outcomes. Supervision is only one of many suggestions made in the literature to support inclusion of PSS in the mental health workforce. The experience and training of NPS in supervision constitute another unknown. It might be assumed that experienced supervisors embody the necessary attributes that form the basis of a successful positive experience for PSS. Future research could look at that hypothesis.

A critical question for future research is how does supervision by NPS differ from supervision by peer supervisors? The desire for PSS supervision was strong and compelling. An assumption is that such supervision supports the peer identity but what other characteristics distinguish peer supervision from non-peer supervision?

This study did not attempt to identify how recovery focused the employing institution was. Does the degree of recovery orientation of the agency or NPS impact the

PSS and NPS relationship? It also is not known what agency strategies had been employed to support PSS role integration.

Conclusions

Despite its limitations, this is one of the first studies to try and understand the experiences of PSS supervised by NPS in adult community mental health settings. It represents a reasonable first step to identify the PSS supervisory experiences in the face of limited research. Exploring the PSS experiences of supervision by NPS is important because supervision has been mentioned in numerous studies as a remedy to challenges integrating PSS in the mental health workforce. It also sheds light on the perceived influence of supervision on the work of PSS. Finally, it has given PSS an opportunity to express what they believe about the role of supervision.

This study supports and adds to the many of the recommendations in the Pillars supervisory guidelines (Daniels et al., 2015). The data that emerged supported recommendations that the supervisor should understand and support the role of the peer specialist, be trained in quality supervision skills, and promote both the personal and professional growth of the PSS. This study also underscores that peer support supervision is not a model of clinical supervision and should not be confused with approaches geared toward the supervision of clinical staff. The inclusion of trauma-informed approaches to the Pillars is a strong recommendation.

PSS are working in many arenas that are moving from a medical model of care to a recovery-oriented model of care. Their experiences in these arenas strongly suggest that NPS need to be aware that what they have learned from academic training and experience

is not readily transferable in the supervision of a PSS. In any case, supervisory functions can be enhanced by the additional efforts to address role integration, trauma considerations and a critical eye on supervisor and colleague attitudes that may continue to reflect stigma and negativity.

Peers are now being employed in traditional mental health settings in far greater numbers than ever before. Progress has been slow but steady. Barriers and challenges have been identified, and suggestions such as supervision have been made to address them. Supervision is a much-needed support as PSS strive to provide the best possible services, and confront barriers of discrimination and stigma. Supervision is critical to addressing issues of role integration, lack of role clarity, and role confusion. These issues will continue to persist as systems negotiate the path to transition. Medicaid regulations require that PSS be supervised by a mental health professional as defined by each state. In practice, states have identified licensed mental health professionals as supervisors. This study strongly suggests that PSS want more experienced PSS to supervise them. During this time, PSS will need supervision that additionally addresses their present experiences of trauma.

Lived experience roles are essential to continued mental health system transformation. Success in these roles requires support and an environment that facilitates continued role implementation, development, delineation and retention. All too often, NPS reflect the expectation to "fit in with" the system rather than allow PSS the support and autonomy to be effective professionals in the mental health system.

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Appendix A

Sample letter of invitation to iNAPS

Dear Executive Director of iNAPS,

Mr. Peter Ashenden suggested I contact you and introduce myself to ask your permission to invite members of iNAPS to participate in a research study about supervision of peer support specialists. I am currently a doctoral student in the Department of Psychiatric Rehabilitation and Counseling Professions at Rutgers, the State University of New Jersey.

This is a study that seeks to understand the experiences of peer support specialists supervised by non-peer supervisors in adult community mental health settings. To access participants for individual interviews I am hoping to invite participation via your membership list serve. All individuals and sites involved in this study would remain anonymous.

With your permission, I would like to begin this research shortly. If you are interested, I will send you a copy of the research proposal and would be happy to discuss this project with you in greater detail. I can be reached at forbesjl@shp.rutgers.edu or 732-995-2258. Thank you for your anticipated interest and time.

Sincerely,

Joanne Forbes, BSN, MA, CPRP

Appendix B

Invitation to participate, informed consent and demographic survey included in REDcap

survey: https://research.njms.rutgers.edu/redcap/surveys/?s=L7WMT4FRDC

You are invited to take part in a research project that will study how individuals who are peer support specialists (PSS) experience supervision by non-peer supervisors (NPS). PSS are known by many names: certified peer support specialist, peer worker, peer supporter, peer family supporter, etc. You are invited to take part even if your exact title is not peer support specialist. If you are a peer employed to support another peer in an adult community health setting, you are eligible to take part. There are two parts to this study. The first part is to complete an online survey that will take about 5 minutes and will ask questions about you, your education, your employment setting and supervision history.

The second part of the study is an interview. Not all participants who complete the survey will be selected to complete the interview, but by completing the survey you are agreeing to potentially be contacted to participate in the interview. You have the option to withdraw your participation at any time. By taking part in this study, you are contributing to what we know about the experiences PSS have had in supervision with NPS working in adult community mental health settings. As PSS join the mental health workforce, it is important to understand how supervision best supports the PSS in their role.

Who can be in this study? In this study, participants will be chosen from candidates who work or have worked as a peer support specialist, are at least age 18 and are/were supervised by NPS in an adult community mental health setting for a minimum of twelve months or have a minimum of twelve supervisory sessions. In order to be interviewed via Zoom, an electronic videoconferencing tool, it is also necessary for participants to have access to a computer in a private setting with Internet, audio and video capabilities. In all, there will probably be a minimum of 25 people invited to participate.

What will be done? You will complete a survey, which will take about 5 minutes to complete. The survey includes questions about you, your education, your employment setting and supervision history. The survey asks you to participate in a follow up interview. If you agree to participate, after you complete the questionnaire, we will examine your responses and will record non-identifiable information about gender, age, education, employment setting, type and amount of supervision. Participants who are interested will become part of a pool of candidates who may or may not take part in one in depth conversational interview. All interviews will be via Zoom (an electronic video conferencing tool) and will take place in a location that is neutral and convenient for you.

 During the interview, I will ask questions about your experiences of supervision as a peer support specialist. The interviews will generally be about 30 and 45 minutes in length. Zoom provides a video and audio recording of the interview so I can be sure of what you tell me.

If you would like to follow up with this interviewer after the interview to add or clarify comments, contact information will be provided. You may also have access to the summary study results upon request.

How will your information be kept confidential? What you tell me is strictly confidential and will be kept anonymous. At no time will your identity or the identity of your supervisor or place of work be disclosed. When the interview is finished, it will be transcribed using a professional transcription service and secured in a password secured computer. All possible safeguards will be in place to maintain your anonymity. No individual who takes part in this study or their place of employment will be identified in any report or publication of the study or its results.

What are the benefits and risks of participating in this study? The benefits of participation in this study is the experience of being someone who has added to what we know about peer supervision by NPS. This knowledge may very well contribute to what supervisors need to know to support PSS. There are no risks anticipated from taking part in this study. If you feel uncomfortable with a question, you can decide to withdraw from the study altogether. If you decide to quit at any time before you have finished the questionnaire, your answers will NOT be recorded.

If you decide to continue, we will ask you to include just your name, State and contact information. You will be contacted by this researcher via the preferred method you indicate in the survey. Arrangements for the follow-up interview will be made at that time. Your name and contact information will not be stored with data from your survey or data from your interview. Instead, you will be assigned a participant number. The

researchers will see your individual survey responses and the results. Once data collection is complete, your e-mail address will be deleted and no link between the survey data and identity will exist.

Your participation is voluntary; you are free to withdraw your participation from this study at any time. If you do not want to continue, you can simply leave this website. If you do not click on the "SUBMIT" button at the end of the survey, your answers and participation will NOT be recorded. If you click on the "SUBMIT" button at the end of the survey, you will be entered in a drawing for a $100 credit card.

If you have any questions either before or after the interview, I can be reached at forbesjl@shp.rutgers.edu. If you have questions about your rights as a research subject, please contact the IRB Director at (973)-972-3608 Newark/ (732)-235-9806 New Brunswick/Piscataway. By beginning the survey, you acknowledge that you have read this information and agree to participate in this research, with the knowledge that you are free to withdraw your participation at any time without penalty.

Consent to participate Statement: "I have read the information provided above and voluntarily agree to participate in this study. I understand that I will be interviewed via Zoom (an electronic video conferencing tool) and that everything I say will be kept private.

Please select one of the following answers:

o   Yes, I agree to participate in this study

o   No, I do not agree to participate in this study

Please provide the following with contact information:

What is your name? _____

What is your personal(non-work) email? _____

What is your phone number _____ (Please provide a

personal NOT a work phone number)?

I prefer to be contacted by:

- Email
- Personal phone
- No preference

What is your age?

- Under 18 years of age
- Over 18 years of age
- Between 18 -26
- Between 27-36
- Between 37-46
- Between 47-56
- Over 56

What is your gender?

- Male
- Female
- Other

What is your race/ethnicity?

- Black
- Hispanic/Latino
- Pacific Islander
- Indian/Alaskan
- Asian
- White
- Other

What is the gender of your current supervisor?

- Female
- Male
- Other

If known to you, what is the race/ethnicity of your current supervisor?
o   Black
o   Hispanic/Latino
o   Pacific Islander
o   Indian/Alaskan
o   Asian
o   White
o   Other
o   Unknown

Do you work in a community mental health setting with adults?

o   Yes

o   No

Where do you work? What kind of employment setting?
o   ACT team
o   Intensive Case management team
o   Case management
o   Partial Hospital setting
o   Outreach team
o   Other –
      If you chose Other please specify what kind of employment setting you work in

_____

How long have you been in your current employment? Specify _

How satisfied are you with your current employment?

o   Very Satisfied
o   Moderately satisfied
o   Satisfied
o   Dissatisfied
o   Very dissatisfied

Are you supervised in your current employment by a non-peer supervisor?
o   Yes
o   No
            What profession does your current supervisor belong to?

o   Mental Health Counselor

- o   Social Worker
- o   Addictions Specialist
- o   Nurse
- o   Psychologist
- o   Other

Have you had supervision by a non-peer supervisor for at least twelve months or a

minimum of twelve supervisory sessions?

- o   Yes
-          No
-          Do you have access to a computer with Internet, audio and video capabilities?
- o   Yes
- o   No

Identify the State where you currently work: Choice of all States

What's the highest level of education you have completed?

-          Less than High School
- o   High school or GED
- o   Associates degree
- o   Bachelor's degree
- o   Master's degree
- o   Doctorate degree

Have you previously been employed anywhere else as a peer worker?

- o   Yes
- o   No

How long including all employment have you been working as a peer worker?

- o   0-6 months
- o   6 months-1 year
- o   1-5 years
- o   5-10 years
- o   over 10 years

Have you been employed in a field other than peer provider?

- o   Yes
- o   No

What type of previous employment did you have? _____

Have you been supervised in previous employment?

- o   Yes

o   No

Appendix C

Semi -Structured Interview Guide

PURPOSE OF INTERVIEW: I am interested in talking to people who work as peer support specialists (PSS) to find out about their experience of supervision with a non-peer supervisor. What you share will contribute to what we understand about the place of supervision in employment as a peer support specialist. I will be video and audio-taping this via Zoom. You agreed to this in the survey, are you still okay with it?

Semi-structured questions for PSS:

How did you become interested in being a peer support specialist?

Tell me a little bit about where you work.

What were your expectations regarding your role as a peer support specialist?

Now think about your experience with supervision with your current supervisor.

I am going to ask you to recall in as much detail as possible supervision sessions where you are currently employed that are memorable to you. They can be memorable for any reason, positive or negative.

Tell me in as much detail as you can. What was the situation surrounding the memorable supervision? What happened in that supervisory session? What aspects of the experience stand out for you? What was the outcome as a result of that experience?

PROMPT- Tell me about another time.
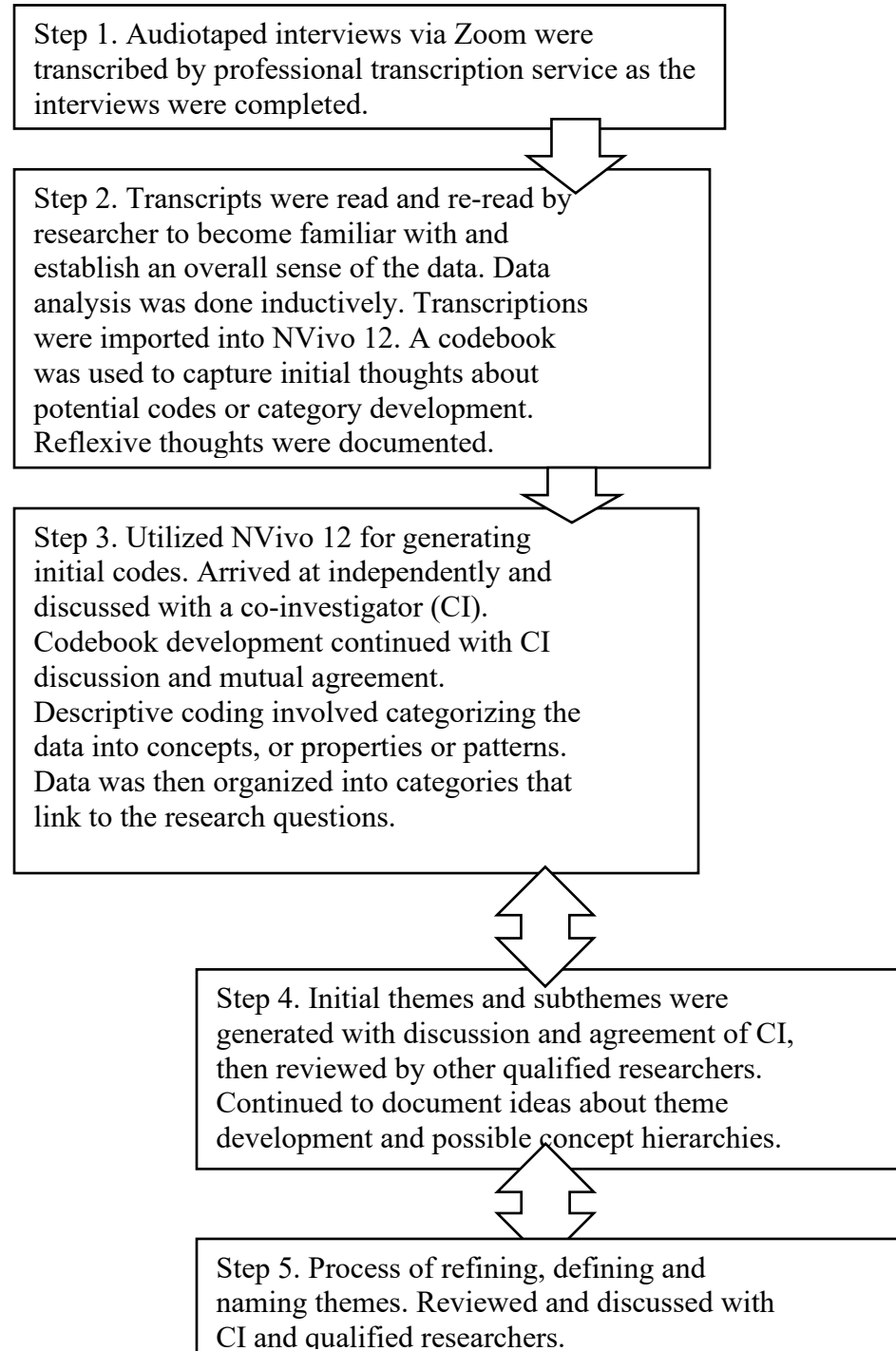
How has supervision influenced your work as a peer support specialist?

What do you believe is the role of supervision for your work as a peer support specialist?

What else do you think it important for me to know?

This concludes the interview. Thank you for your time and interest. While the recording

is still on, I'm curious to find out what was it like being interviewed for you?

Appendix D

Data Analysis Procedures

Step 1. Audiotaped interviews via Zoom were transcribed by professional transcription service as the interviews were completed.

Step 2. Transcripts were read and re-read by researcher to become familiar with and establish an overall sense of the data. Data analysis was done inductively. Transcriptions were imported into NVivo 12. A codebook was used to capture initial thoughts about potential codes or category development. Reflexive thoughts were documented.

Step 3. Utilized NVivo 12 for generating initial codes. Arrived at independently and discussed with a co-investigator (CI). Codebook development continued with CI discussion and mutual agreement. Descriptive coding involved categorizing the data into concepts, or properties or patterns. Data was then organized into categories that link to the research questions.

Step 4. Initial themes and subthemes were generated with discussion and agreement of CI, then reviewed by other qualified researchers. Continued to document ideas about theme development and possible concept hierarchies.

Step 5. Process of refining, defining and naming themes. Reviewed and discussed with CI and qualified researchers.

Appendix E

Trustworthiness Protocol

Criterion	Activities	Process
Credibility	1. Purposeful sampling 2. Member checks-. Encouraged participants to add or clarify comments with interviewer post interview. Summary of final results sent to participants for comment. 3. Journaling- notes taken after each significant activity 4. Prolonged engagement with the data 5. Data analysis triangulation 6. Peer debriefing	1. Invited participation of PSS supervised by non-peer in adult MH settings. 2. a. Participants were told that they could add or clarify comments after the interview by contacting the interviewer via provided email address. b. A summary of data from final stages of analysis was sent to participants for review 3. a. A reflexive journal was kept after each interview to capture reflections. Entries included dates, time, place and persons involved. b. Notes were taken after each data analysis session to reflect the thought process associated with identifying codes and themes. 4. As interviews were transcribed the data was read and re-read to ensure familiarity 5. After data entry into NVivo 12, co-investigator was involved in independently identifying preliminary codes, discussing &, reaching agreement. Codes & themes were developed by this process.

		6. Outside researchers also provided impartial feedback as process of meaning-making unfolded.
Transferability	1.Thick, rich description	1. a. Semi-structured interview format which supports consistency within interviews was used. b. CIT questions identified precursors, situation, and outcome in detail. c. Prompts were used during interview to assist participants to provide as much detail as possible. d. Details about interview itself -where it was held, length of interview and any other pertinent information was documented.
Dependability	1. Created both a physical and intellectual audit trail. 2. Audit performed by outside researcher.	1 a. A physical audit trail was generated by documenting detailed reflections of thoughts, experiences and ideas surrounding interviews. b. Raw data was available for review c Memos about data reduction and data analysis were created d. As well as memos about theme development

		2	An outside researcher (Dr. W. W.) reviewed audit trail which included specifics of each step of the research process
Confirmability	1. Analyst triangulation 2. Triangulation of sources 3. Audit trail	1.	Outside researchers (R.C., Dr.R.E., Dr.P. R-P and Dr. A.S.) were involved in reviewing data analysis and theme production after initial code development. Outside researchers have conducted qualitative research and participated in team coding.
		2.	Participants from different settings; participants with different employment and supervision histories and of different ages were included.
		3.	The audit trail was developed, and reviewed with an outside researcher (Dr. W.W.).