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Impact of Being a Peer Recovery Specialist on Work and Personal Life: Implications for Training and Supervision

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Keywords

Mental health recovery peer; Peer recovery specialists; Peer recovery specialists outcomes; Substance use disorder recovery peer

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ORIGINAL PAPER

Impact of Being a Peer Recovery Specialist on Work and Personal Life: Implications for Training and Supervision

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Abstract

Peer recovery specialists are an important resource in community mental health settings. This study, which was part of a larger statewide assessment, evaluates how the role impacts work and personal lives of peers, with implications for improving the training and supervision of this service. The importance of peer work has been investigated through client outcomes, however less work has investigated outcomes on peers themselves, which impacts the work force and service delivery. Nine focus groups were conducted with peer recovery specialists. A two-stage qualitative analysis led to two overarching themes, work and personal, and six subthemes. Findings suggest being a peer presents unique benefits and challenges in work and personal life. Peers benefit from more training and supervision, consistency within the role, and maintaining boundaries. Additionally, work environment roles may be improved by attention to needs of supervisors in terms of skills for effective supervision and clarification of supervisory roles.

Keywords Peer recovery specialists · Substance use disorder recovery peer · Mental health recovery peer · Peer recovery specialists outcomes

People with lived recovery experience who provide services to others going through recovery, are known as Peer Recovery Specialists (U.S. Department of Health and Human Services, 2015), this approach has existed for several decades (Davidson et al., 1999; Soloman, 2004). For simplicity, for the remainder of this article, PRS will refer to the singular (Peer Recovery Specialist) or the plural (Peer Recovery Specialists), depending on context. For clients, the PRS presents many potential benefits. PRS can provide a sense of community, encouragement, hope, and knowledge of what to expect during recovery (e.g., how to access services; Daniels et al., 2012; Salzer et al., 2013). PRS serve many roles, including providing emotional support and informational resources for people seeking substance use and/or mental health services, being role models, and helping clients overcome barriers (Klee et al., 2019). The role of being a PRS can also be associated with both benefits and challenges for the individual providing services (Moran et al., 2013; Salzer et al., 2013).

Bassuk et al. (2016) conducted a systematic review on peer recovery services for substance use, and generally found positive impact on outcomes for clients in multiple areas (e.g., substance use, re-hospitalization, treatment plan adherence). In addition to reviewing the positive client outcomes, Bassuk et al. (2016) also provided information on the impact that the role of being a PRS has on the individual providing the services, which is the primary focus of the current study. Within and across studies, Bassuk et al. (2016) found wide variation in PRS requirements and training, unclear PRS roles and guidance on how to relate to other professionals,

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and questionable reimbursement rates for PRS services. Role confusion and devaluation of the PRS by other professionals has been noted previously in the literature (Moran et al., 2012). This suggests PRS may experience conditions that could enhance or detract from their own experience as a PRS (e.g., getting paid for services vs not getting paid; role clarity vs lack of role clarity).

Moran et al. (2012) conducted a mixed-methods analysis to investigate the personal growth and recovery in PRS. Multiple themes emerged in three domains encompassing work environment, occupational path, and mental health for the PRS. Work environment challenges included lack of infrastructure, low pay, prejudice towards PRS, lack of initial orientation to the work environment, problems with supervisors, isolation (being the only peer), and unclear roles. With respect to occupation, peers expressed having insufficient knowledge, lack of congruence between training and job, gaps in training, tasks that are not included in roles, devaluation of lived experience, and difficulties establishing peer-relationships and helping relationships. Challenges with respect to mental health included experiencing job stress during non-work time, secondary trauma, and depression. In a later study, similar difficulties were found including limited compensation, conflicts with employers, work stress, abundance of paperwork, and lack of employment opportunities (Ahmed et al., 2015).

In spite of the above difficulties, PRS may gain some benefit from their work including self-knowledge, support systems, career skills, and enhancement of their own long-term recovery (Salzer et al., 2013). Being a peer engenders confidence in their own abilities, and encourages coping, self-esteem, and empowerment (Soloman, 2004). PRS find many aspects of their professional work rewarding including helping others, developing peer-to-peer relationships, sharing recovery stories, and experiences of personal growth (Ahmed et al, 2015). Salzer et al. (2013) found multiple benefits to being a PRS. Becoming a PRS enhances employment opportunities, reduces need for mental health services, improves coping skills and recovery, and provides a sense of efficacy, hope and meaning.

While much work has been conducted to determine the effectiveness of PRS on client outcomes, less research has studied outcomes for PRS themselves. The current study focused on the benefits and challenges experienced by PRS in two environments: work and personal. While the above literature review indicates some important work has begun to investigate the impact of peer recovery services on PRS themselves, the present study adds to this literature by replicating and extending past findings.

Peers in recovery (certified and in training) were provided with questionnaires using fixed-choice questions; then were asked to engage in focus groups. Given the prior literature, it was determined, a-priori, that focus group results would first be examined in two major themes encompassing work and personal spheres. In the second stage of analysis, researchers sought a posteriori (emergent) codes and subthemes to "reflect the views of participants" in a traditional qualitative way (Creswell & Poth, 2018, p. 193). This approach allowed for efficient, in-depth investigation of the impact of peer work on peers themselves (both professionally and personally), as it permits both more private and more public responses to inquiries. Gaining better understanding of the impact of peer recovery work on peers themselves will inform practice in the field in terms of training and supervision.

Methods

Participants

The study was conducted as part of a statewide evaluation of PRS training. Effective qualitative sampling relies on purposeful selection of participants who can "provide the most information-rich data possible" (Morrow, 2005, p. 255). In this study, participants were recruited from all organizations, who conducted training for PRS, within one Northeastern state. Participants were recruited at the agencies where they were working. Agency staff were asked to hang flyers and promote the focus groups within their organization. Focus groups were conducted through agencies where people were either trained or employed as a PRS. Participants were permitted to participate in focus groups during work hours or outside of work hours, and those participating during off-hours were compensated with $20 (state law does not permit payment for such activities during work hours). During consent, participants were given the option of having the form read to them or reading it themselves. They were informed that the purpose of the study was to evaluate the system of peer recovery in the state, and participation was voluntary. Participants and researchers did not have personal relationships outside the context of the study and made contact only through study procedures.

The sample was comprised of 63 peers with at least two consecutive years of recovery (25 certified, 38 in training) spread out over nine focus groups. Participants had to be either in training to become a PRS or be a certified PRS. Certification requires a 46-h training, completing 500 h of experiential training and taking a certification exam. For peers currently in training, there were 23 (65.7%) White/non-Hispanic, 2 (5.7%) White/Hispanic, 3 (8.6%) Black, 1 (2.9%) Asian, 1 (2.9%) Hispanic/ Latinx, 1 (2.9%) Native American, and 4 (11.4%) Other/Not Listed. There were also 21 (60%) women, 10 (28.6%) men, 1 (2.9%) fluid, and 1 (2.9%) other, with an average age of 43.3 ($SD = 11.9$). For peers that have obtained certification, there were 14 (56%)

White/non-Hispanic, 1 (4%) White/ Hispanic, 4 (16%) Black, 1 (4%) Asian, 1 (4%) Hispanic/ Latinx, 1(4%) Native American, and 3 (12%) Other/Not Listed. There were 17 (68%) women and 8 (32%) men, with an average age of 43.4 ($SD = 11.6$). Although appropriate sample size for qualitative studies can vary, $N = 50$ is considered large and generally adequate (Boddy, 2016). Qualitative literature emphasizes the importance of garnering information-rich data that offers nuanced insight into complex topics (Morrow, 2005; Patton, 1990)—such as those described in this paper. Therefore, the final sample size of $N = 63$ across 9 focus groups was determined to be more than acceptable for analyses.

Data Collection

All materials were approved by the University of Rhode Island Institutional Review Board (IRB). The materials were created by the second author with guidance and feedback from key stakeholders including a state-wide PRS Advisory Board, the state's department of behavioral health, developmental disabilities, and hospitals, and a university faculty member with expertise in behavioral and addiction sciences. Qualitative data were collected through focus groups (Stewart et al., 2007), moderated by the second author for the purpose of a larger study investigating PRS training. The moderator followed a protocol with a series of questions (and pre-determined probes) to be asked during the focus groups (see Table 1). Data were collected during a three-month period in 2019. Focus groups were conducted in private (i.e., non-PRS agency staff not permitted) settings. Focus groups lasted between 30 min and 120 min, depending on the size of the focus group and how talkative the participants were. Since the data collection was part of a larger statewide project with focus group sessions scheduled by the state and providers, not all focus groups had equal turnout which impacted the variability in the length of time of the focus group. Smaller focus groups tended to be shorter because there were fewer participants to respond to the questions. Participants were not put into separate focus groups based on their demographics due to participant availability and protocols set prior to focus groups being conducted. However, there were no significant differences for age ($F(8, 46) = 1.092$, $p = 0.39$), gender (χ^2 $(24) = 22.28$, $p = 0.56$), or race ($\chi^2(48) = 61.79$, $p = 0.09$). Participants completed a questionnaire before the beginning of the focus group (see below). All focus groups were recorded on a password protected iPhone, then uploaded to a transcription website (see below for details).

Questionnaire for Peers in-Training

The questionnaire designed for peers in-training was 17-items. Most questions were fixed-choice and pertained to the following areas. (1) Decisions on becoming a PRS – Example: What led you to become a peer recovery specialist? Response choices: Personal experience in mental health, substance use, both, or other. (2) Support for becoming a peer – Ex.: I feel supported by my friends/family/significant others throughout my training, with responses on a 5-point Likert scale from 1 = Strongly Disagree to 5 = Strongly Agree. (3) Getting adequate oversight during training – Ex.: I have enough contact with my supervisor; response choices reflected the above 5-point Likert scale.

Questionnaire for Certified Peers

The questionnaire designed for certified peers was 21-items that contained items similar to the above fixed-choice questions (e.g., What led you to become a certified peer recovery specialist?). In addition they responded to a series of fixed-choice items on current work as a PRS including: (1) How much they agreed that they would be worried about their job security if they had to take time off for health-reason (1 = Strongly Disagree to 5 = Strongly Agree); and (2) How many visits, on average, it takes for clients to open up to them, responses ranged from 0 to 5 or more.

Focus Group Protocol

The focus group protocol contained 13 questions. Questions addressed the 46-h training, the 500 h of experiential training, certification exam, what it means to be a PRS, and how they are affected by being a PRS. Specific questions most relevant to this paper included, but were not limited to: (4) "Has your role as a CPRS/Recovery Coach impacted your life in a positive/negative way?" (5) "Please describe why you do/do not feel supported enough to prioritize self-care." (6) "If you could change/add any one thing to your training process, what would it be? Why?" (7) "What do you think the strengths and/or limitations of your current employment setting are?" Prior to starting focus groups, participants were asked to complete the brief questionnaires in private. Once completed, the moderator asked each participant to create a pseudonym and followed a set script for introductions. When completed, the moderator began asking questions and probed, when needed. At the end of the focus group, the moderator asked if there was anything else they wanted to share and then thanked participants for joining.

Data Analysis

For the questionnaires, descriptive statistics were generated using Statistical Package for Social Sciences (SPSS ver 25). Questionnaire items using Strongly Disagree to Strongly Agree were condensed into Agree (Strongly Agree and Agree) and Ambivalent/Strongly Disagree (Neither Agree or

Table 1 Focus group protocol

1. Overall, how satisfied are/were you with your 46-h training?
a. Were there any barriers to training completion/certification that you faced in the 46-h component
b. Any facilitators that aided in completing your training?
c. Struggling personally, professionally, experientially
d. Struggling with materials
2. Overall, how satisfied are/were you with your 500 h experiential component?
a. Were there any barriers that delayed your completion?
b. Any facilitators that aided in completing your training?
c. Struggling personally, professionally, experientially
d. Struggling with materials
e. Struggling with the sheer amount of hours
3. Was there anything you wanted/needed more/less of during training? Please describe if so
a. Either training experience
b. Topics outside of your knowledge base
c. Relating to others/interpersonal skills
d. Training on self-care
e. Computers/technology
f. MAT
g. Justice system
h. Any other skills?
4. Has your role as a CPRS/RC impacted your life in a positive/negative way?
a. Do you feel disconnected from friends, family, or significant others or more connected
b. Has your mental health worsened or improved?
5. Please describe why you do/do not feel supported enough to prioritize self-care
6. If you could change/add any one thing to your training process, what would it be? Why?
7. What do you think the strengths and/or limitations of your current employment setting are?
8. What training, if any, did you get in assisting persons in Medication Assisted Treatment (MAT) programs?
a. How much do you feel such training would help you in your role?
9. What is your personal experience with MAT, if any (you've used it, a family member or close friend has used it, etc.)?
10. How do you engage your clients in recovery supports and keep them engaged over time?
11. If you needed to take a break from your training or your role as a CPRS/RC, do you feel supported enough to do so?
12. Have you come across any point in your training or employment where you found yourself struggling in any capacity? If yes, how so?
a. Personally (personal life)
b. Professionally
c. Experientially (500-h)
d. Understanding materials (46 h or exam)
13. Have you come across a point in your training or employment where you found yourself inspired in some capacity? If yes, how so?
14. How do/did you feel about the certification exam?
a. How prepared do you feel to take the certification exam?
b. Anxious/Nervous/Excited…?

Disagree, Disagree and Strongly Disagree). The item asking about number of visits until clients open-up was condensed into 0–1 (immediately opened-up – after 1 visit), 2 (after 2 visits), 3 (after 3 visits) and 4–5 (after 4 or more visits).

Since this manuscript emphasizes qualitative results from focus groups, those analyses are the focus of the remainder of this section. Each focus group was audio recorded and transcribed using Temi (online transcription site, https://www.temi.com/). Transcripts were then checked for discrepancies (between recorded and written content) and cleaned by two trained members of the research team. For focus groups, the team used ATLAS.Ti 8-Windows to organize codes and themes.

The research team used two stages of analytic methods—a priori (e.g., codes predetermined) and a posteriori (e.g., emergent codes) coding—to organize participant experiences and develop relevant themes (Creswell & Poth, 2018; Patton, 1990). Table 2 shows that an overwhelming majority (91.4%) of certified PRS and those in training went into the field based on their own experiences with both substance

Table 2 Reason for becoming PRS or certified PRS ($N=63$)

Reason for becoming a PRS or certified PRS	Frequency (%)
Own experiences with mental health (MH) issues	22 (35.9%)
Own experiences with substance use (SU) issues	5 (7.9%)
Own experiences with both MH and SU issues	30 (47.6%)
Other reasons	2 (3.2%)
No response	4 (6.4%)

PRS peer recovery specialists

use and/or mental health. These demographics, as well as the literature on PRS noted earlier, informed the choice of two overarching a priori coding categories: work and personal. Creswell and Poth (2018) note that a priori codes are often used in health sciences when the literature offers useful constructs—such as work and personal relevance to the PRS role. In stage one of qualitative analysis, researchers reviewed the transcripts independently and initially coded data into these overarching a priori themes (i.e., work, personal). In the second stage of analysis, researchers reviewed the data again looking for a posteriori codes—that is emergent patterns in the data relevant to a priori themes of work and personal. Qualitative researchers combine similar or complimentary "a posteriori code segments that can be used to describe meaningful information units and develop [sub-]themes" (Creswell & Poth, 2018, p. 193). For instance, the following a posteriori codes were combined to craft the emergent sub-theme titled burnout: working long/extra hours, heavy client loads, feeling emotionally drained, lack of solutions/resources, and taking problems home. In the results section, code segments that comprise each of the emergent sub-themes are listed and then selected quotes offered as evidence. The final emergent (a posteriori) sub-themes related to work included (1) funding problems, (2) role-specific benefits, and (3) role-specific challenges. Under personal, emergent sub-themes included (1) burnout, (2) self-care, and (3) inspiration. Disagreements were discussed and final a posteriori code was decided with consensus among raters and put into ATLAS.ti.

Trustworthiness & Credibility

The team used a variety of qualitative strategies to achieve trustworthiness and credibility (Lincoln & Guba, 2007; Morrow, 2005; Patton, 1990). First, the team used inter-rater reliability with three team members independently analyzing each transcript. There was 80.2% agreement during the initial round of coding. The codes sub-themes, and themes were reviewed and discussed during team meetings and final versions of each were determined only after consensus among all raters. Second, the team used triangulation of data from nine different focus groups at the various collection sites, as well as between focus group and questionnaire data. Third, the team utilized expert reviews at each stage of the research process. For instance, experts in behavioral health, recovery work, and PRS informed the development of the project—including the design, implementation, and analysis of focus group data. The team also sought an external audit (Lincoln & Guba, 2007) from a qualitative expert with 15 years of experience publishing qualitative studies and teaching qualitative courses at the graduate level. Fourth, the team used dual strategies to engage in reflexivity: peer debriefing (at research team meetings) and individual researcher reflections on their assumptions, values, and perspectives on the research topics, processes, and products. The team is comprised of white women ranging in age from 21 to 65; 3 were trainees in behavioral sciences; 3 were professionals in the behavioral sciences or healthcare field including one with clinical background and another with experience as an attorney; and one was a qualitative expert with a background in human development. One of the co-authors was a PRS expert who spearheaded the use of PRS in the state. Combined, the years of experience in the field of behavioral health, peer recovery, and qualitative evaluation methods ranged from 1 to 20 years. The team used this diversity of expertise as a strength. The graduate students and undergraduate students on the project, attended regular research team meetings where they received ongoing training, shared readings, and learned from one another about PRS and qualitative methods. Since this study was part of a statewide evaluation, the criterion of educative authentication (Lincoln & Guba, 2007) was used as the fifth method. Lincoln and Guba (2007) explain how this trustworthiness criteria is important for qualitative evaluations wherein "each stakeholder…should have the opportunity to become educated about others of different persuasions (values and constructions), and hence to appreciate, how different opinions, judgments, and actions are evoked" (p. 23). In this study, educative authentication was achieved in two ways: (1) through co-learning among participants during focus group dialogue and (2) through transparent sharing of final reports to the agencies that took part in the evaluation. In sum, these strategies, combined with "coherence" in themes "grounded in data" (Morrow, 2005, p. 257) were implemented to produce trustworthy and credible research (Lincoln & Guba, 2007; Morrow, 2005).

Results

Questionnaire Results

Complete questionnaire results are reported elsewhere (Roy et al., 2020). However, effective qualitative data is best understood and applied effectively when rich qualitative data are

Table 3 Supervision, support and internship funding for peers in training ($N=35$)

Question	Frequency (%)		
	Yes	No	NR
Currently funded (500-h training)	11 (31.4%)	11 (31.4%)	13 (37.1%)
	Yes	Ambiv/No	NR
Enough contact with supervisor	25 (71.4%)	9 (25.7%)	1 (2.9%)
Friends/family/sig. other training support	32 (91.4%)	3 (8.6%)	0 (0%)

NR no response, *sig.* significant, *Ambiv* ambivalent

presented within "narrative developed about the context" (Lincoln & Guba, 2007, p. 19). As such, selected questionnaire results—those most relevant to the qualitative data about the personal and work impacts of PRS roles—are summarized. See Tables 3 and 4 for a summary of key results. Most participants reported being are well-matched to clients (84%), having enough time with clients (72%), as well as manageable caseloads (72%). Over 90% of PRS received support from family and friends during training. In contrast to these positive results, participants reported less favorable experiences related to financial and work-related experiences. For instance, less than half are reimbursed for internship work. Over 75% of certified PRS are paid for services, but more than half are concerned about job security if they take time for their own recovery needs. Almost a third of PRS reported negative or ambiguous responses to the question about getting enough time with supervisors. These results contextualize the nuanced data gleaned from the focus groups.

Focus Group Results

Work and personal benefits and challenges experienced by PRS were investigated. Three subthemes fell under work theme and three subthemes fell under the personal theme. The subthemes under work included (1) funding problems, (2) role-specific benefits, and (3) role-specific challenges. Under personal, subthemes included (1) burnout, (2) self-care, and (3) inspiration. In each of the following sections, the following structure is followed: sub-theme is described, code segments that comprise each of the emergent subthemes are listed, and then selected quotes are offered as evidence. Examples and frequencies of each theme and subtheme are provided in Table 5.

Work Environment

Persons who described situations within the workplace were considered to fall under the work environment theme. This included people describing funding issues, benefits of the position, and challenges of the position.

Work Environment: Funding Issues

Participants discussed issues with funding provided to PRS and services they provide. Within the funding issue subtheme, topics discussed by participants (and coded by the team), included not being paid enough, programs not budgeting for peer services, lack of support resources, lack of employee benefits, and lack of security, and inability to bill for services. When discussing not being paid enough participants stated things like, "I can't afford it, and it's sad because I don't want to leave this agency. And I don't want to leave

Table 4 Work experiences for certified peers ($N=25$)

Question	Frequency (%) or M (SD)				
	Yes	No	NR		
Employed as PRS	21 (84%)	4 (16%)	0		
Paid for PRS services	19 (76%)	2 (8%)	4 (16%)		
Time with clients is enough	18 (72%)	4 (16%)	3 (12%)		
Case-load manageable	18 (72%)	2 (8%)	5 (20%)		
Clients per caseload		14.3 (13.4)			
	Yes	Ambiv/No	NR		
Worry about job security if took time for own mental health	13 (52%)	11 (44%)	1 (4%)		
Feel well-matched with clients	21 (84%)	2 (8%)	2 (8%)		
	0–1	2	3	4+	NR
Visits before clients opened up	2 (8%)	4 (16%)	4 (16%)	2 (8%)	13 (52%)

M mean, *SD* standard deviation, *PRS* peer recovery specialist, *NR* no response, *Ambiv* ambivalent

Table 5 PRS theme, subthemes, and codes ($N=63$)

Theme	Subthemes	Subthemes codes	Frequency (%)
Work environment	Funding problems	Not being paid enough, programs not budgeting for peer services, lack of support resources, lack of employee benefits, and lack of security, inability to bill for services	13 (20.6%)
	Role-specific benefit	Being part of a team, advocating for clients, enjoying educational outreach, appreciating the support role of PRS, feeling pride in the work, and gaining valuable training	29 (46.0%)
	Role-specific challenge	Clients missing appointments, lack of resources for PRS education initiatives, feeling overworked, and lack of sufficient supervision, lack of direct-care opportunities, challenges of navigating addiction stigma, difficulty maintaining boundaries, and the unpredictability of the work	16 (25.4%)
Personal environment	Burnout	Working long/extra hours, emotionally drained, lack of solutions/ resources, taking problems home	7 (9.5%)
	Self-care	Prioritizing self-care, encouragement for self-care, and strategies that foster self-care	36 (57.1%)
	Inspiration	Seeing clients grow, work hard, and succeed; inspiration fostered strong connections with clients; inspiration and sense of purpose	17 (27.0%)

Not all respondents provided answers within a theme so that response frequency could be less than 63

this field, but I have a family to take care of" and "I have to work a second job." Comments made about programs not budgeting for peer services included, "When the organization I work for lost its budget, we had just struggled to get it back." When discussing lack of resources participants stated, "And it's so hard to find resources … I see homeless people in my job every day and they can't get on housing lists because they're just waiting to get a little bit of income. And, it's just like the circle." When discussing lack of employee benefits it was stated, "I've had the same problem, with my health insurance, I have the same exact problem. I can't have health insurance through my job because ~" someone else interjected to finish the sentence "It's more expensive." Another participant concurred: "I'm in the same boat with you guys, with what you're saying, I mean I work here and work full time and still I'm on state insurance. I can't afford to even have insurance through here because it's too expensive." When discussing lack of security participants said, "financial instability has been a huge issue." Respondents noted that they took pay cuts to become a PRS, one participant stated "…but I'm making less money now than I was before because I want to do this and I'm going to school to do this." Lastly, inability to bill for services was a problem. One person stated, "…I'm always told all the time that I can't see my clients once a week because of billing issues, and can't have more than five hours because they're considered ACT team" (ACT is Assertive Community Treatment). Comments about work-related funding issues were made by 13 (20.6%) of the total 63 participants.

Work Environment: Role-Specific, Benefits

When participants discussed benefits of their role as a PRS regarding the workplace, such as, skill and career development and satisfaction at work, it was considered a role-specific benefit. Codes for this subtheme included: being part of a team, advocating for clients, enjoying educational outreach, appreciating the support role of PRS, feeling pride in the work, and gaining valuable training. When participants discussed how their role benefits their personal life, such as their work inspires them, they were not coded as role-specific benefits. Out of the 63 total, 29 (46%) participants discussed role-specific benefits of being a PRS. Topics included enjoying being part of a team and advocating for clients. One participant stated, "…I needed to be able to continue to advocate for my peers, as much as possible." Another stated, "I do go to the hospital with them and…I make sure the nurses and doctors know exactly what's going on with this person." They enjoy education outreach as well. One participant stated, "I've been on a couple of NAMI presentations to the youth, where you go in and share your personal story…I've seen 'aha' moments with students." (NAMI is National Alliance on Mental Illness). Another stated, "Pretty much every school we go to is like, 'Oh, we would love to have one of you working with us.'" Many respondents relished the supportive role they play as a PRS and sharing their own experiences with clients. For example, one PRS stated s/he liked "being a role-model, friend, peer, and providing encouragement." Respondents often had a sense of pride in their work, and one in particular stated, "I also help facilitate a NAMI group here on Mondays and for 10 months now the same people keep coming back. They want to be in

the group." Opportunity for training was another perceived benefit. One participant stated, "I have been trained in parenting, networking, and nutrition…Actually, I'm certified to be a parenting coach." Another participant explained how PRS training enhanced "coping skills" "people skills", "motivational skills", and "speaking skills because you have to…give talks in front of people." These examples show the potential professional benefits of the PRS role.

Work Environment: Role-Specific, Challenges

When participants discussed challenges of their role as a PRS regarding the workplace, it was coded as role-specific challenge. Sixteen (25.4%) of the participants discussed challenging aspects of being a PRS. Codes that comprised this sub-theme included: clients missing appointments, lack of resources for PRS education initiatives, feeling overworked, lack of sufficient supervision, lack of direct-care opportunities, challenges of navigating addiction stigma, difficulty maintaining boundaries, and the unpredictability of the work. Some PRS described a consistent challenge of clients missing their in-home appointments and having difficulty finding transportation to appointments. For instance, one shared that PRS regularly deal "…people have problems with transportation and keeping appointments." Lack of resources to educate the public on availability of PRS was also noted. One participant lamented "people who have been thrown into the woods. Where are they supposed to go? Again, they don't have these resources. I had to literally find these resources so myself." Others said they were overworked: "There is an immense amount of work that like three people are holding on all their shoulders" and "I think sometimes it's just not enough hours to…get everything done." Participants mentioned that they did not have enough supervision, especially after becoming certified, "When I was in the internship at the second location, there was a weekly supervision—because it was mandated, because I was an intern. But as soon as I got hired…you're not an intern [so] we don't have to have supervision." Other drawbacks included not doing as much direct care work as they wanted. One focus group participant explained: "I can't because I'm down there saying I'm bound by the fact that I can give them, um, you know, once a week visits for an hour." Other participants noted difficulty helping clients with stigma relapse saying things like: "if a community sees you…as being this person that misuses substances and you get labeled and there's a stigma that ties in behind that." Participants also discussed difficulty in maintaining boundaries between personal and professional activities saying: "we see a lot of ourselves in certain situations that we deal with, with our members, and it gets scary…Or if you run into somebody that you know, if you're trying to help somebody that you know from the past or anything like that." A final challenge was the unpredictability of work. For example, some peers provide services in walk-in clinics and as stated by one respondent, "So if you don't walk in, I don't do no work." Another participant stated, "I think… there definitely could be more consistency with components of the role."

Personal Environment

Participants described how situations within the workplace affected them personally, and we considered these comments to fall under the personal environment theme. This theme included three sub-themes of: people describing burnout, self-care, and inspiration in their personal life.

Personal Environment: Burnout

Participants discussed how situations from their roles as PRS contributed to burnout which includes symptoms of energy depletion, exhaustion, mental distance from a job, negativity towards job, and reduced professional efficacy (WHO, 2019). The codes that comprised the sub-theme of burnout included: working long/extra hours, feeling emotionally drained, feeling like there are no solutions (i.e., resources), and taking problems home. Participants discussed burnout due to long work hours resulting from picking up shifts, running programs, and going above and beyond the job description. One participant explained: "I do burn myself with additional hours, because I'm a peer that really tries to, which I'm sure we all do, go above and beyond." When discussing being emotionally drained on participant stated, "Like I leave her, I'm emotionally drained… and then I'm stuck in my own grief." Another participant stated "…You begin to, you know, build a rapport and you know, you care for people and when … things happen…It can be emotionally difficult." When discussing lack of solutions contributing to burnout one participant stated, "Talk about burnout… because it feels like there's no solutions, right?" Finally, one participant explained how burnout resulted "because we take problems home."

Personal Environment: Self-Care

When participants discussed how they implemented self-care into their lives, or how supervisors and colleagues encouraged self-care it was coded under self-care. Self-care was raised by 36 (57.1%) participants. Codes combined for the sub-theme of self-care included: the difficulty prioritizing self-care over care for others, the encouragement to care for self, and specific strategies (e.g., flexible schedules) that fostered self-care. Participants struggled to maintain a balance between work and self-care. Some expressed having difficulty in hearing clients' stories and getting "stuck in grief…when you should be focusing on

yourself." Respondents often conveyed that they did not prioritize their own mental health over clients, supervisees, family, and friends. On the other hand, participants noted how peers and professionals encouraged them to take care of themselves. One participant stated, "there was a big emphasis on self-care, which I did love." Another stated, "…my peers that I work with helped remind me that I needed to do more self-care and that really pushed me to start taking better care of myself." Respondents noted that self-care is aided by flexible schedules, reminders that selfcare also helps serve clients better, socializing with other PRS, taking vacation days, working on self-esteem, and "being gentle with themselves" (e.g., "…breakdowns are okay if needed").

Personal Environment: Inspiration

When participants discussed how their job as a PRS inspired (motivated or excited) them in their personal life, to stay sober, or to continue their role as a PRS, it was coded as inspiration. Seventeen (27%) participants noted the inspiration they receive from being a PRS. The codes that made up this sub-theme included inspiration from: seeing clients grow, work hard, and succeed as well as the ways inspiration related to strong connections with clients and a sense of purpose. In particular, they noted that seeing clients grow (developing their own goals and self-esteem), work hard (to overcome trauma, lack of transportation, no money) and succeed was inspiring. When discussing client's growth a participant stated, "it inspires me to see where they were, where they're at now. Um, that's the best part of it." When discussing working hard, one participant stated, "Every day my clients, they inspire me. Them getting out of bed and coming to their appointments make me get out of bed…I'm like, 'I'm so blessed to get paid, to hang out with you individuals that I enjoy being around so much.'" When discussing seeing their client succeed participants stated, "…somebody we talked to definitely is an inspiration…especially when you['ve] somebody, in the ED at their worst and six months, or years later…they're celebrating clean and sober time… It's inspiring every single day what we do." Another stated, "They are why we do this job…they're just so inspiring." An added benefit expressed by some respondents was that this feeling of inspiration helped to build strong connections with clients and helped provide a sense of purpose in PRS.

Discussion

The current study examined the experiences PRS have in work and personal environments. When discussing work experiences, PRS noted more benefits to their roles than challenges. Respondents enjoyed being a role-model, working in multiple different types of facilities and opportunities for training. However, they also felt overworked and underpaid. When discussing how peer work effects them personally, PRS noted working many hours and being underresourced can lead to burnout. On the other hand, such burnout is countered by self-care and the inspiration PRS find in their work.

Financial concerns were noted by over 20% of participants, with those currently being trained noting unavailability of paid internships (from questionnaire data). These concerns appear to be related to systemic issues with respect to reimbursement rates established for services. Once certified, PRS still do not have financial security. Some reported working multiple jobs, while others have taken pay cuts to be a PRS. In a system strapped for resources, it is no surprise that certified PRS are concerned about losing their jobs if they take time off for their own mental health needs (questionnaire data). Especially when PRS have been employed and then written out of budgets when funding becomes tight. This insecurity and instability are crucial to address within this population, given that lived experience with sometimes chronic and relapsing conditions is often central to being a PRS. While advocacy around funding for PRS at the state level is recommended, PRS themselves lament they do not even have time enough to advocate for their clients. While in a role where advocacy for people going through recovery is the most important job, advocacy for job and financial security should be highlighted more.

In their work roles, over 45% of PRS found many benefits including being a team-member, advocating for clients, educating the public, providing groups, and the training they receive. On the other hand, relatively fewer (about 25%) PRS noted challenges in their roles including lack of resources (both at work to perform duties, and transportation to get to work), unpredictability of client contact (missed appointments, few clients during walk-in clinic hours), maintaining boundaries, assisting clients with coping skills, and lack of supervision. Those with supervisory responsibilities noted lack of clarity in how to approach this role in particular. The provision of regular and competent supervision might assist in alleviating some of these challenges; whereas other challenges are likely addressed at a macro-systems level (e.g., public transportation, more funding for services). PRS training curricula that includes topics on maintaining boundaries and assisting clients with coping skills is fundamental and should be reinforced through supervision.

Effects of the PRS work roles included burnout (less than 10% of respondents), inspiration (almost 30%) and the need for self-care (almost 60%), all with ramifications for the personal lives of PRS. Although the sample as a whole felt their caseloads were manageable (about 14 per PRS, see questionnaire data), a few others noted very high caseloads (up to 60 clients) contributing to stress. Burnout was associated with being underpaid, feeling emotionally drained,

and lack of leadership support. Burnout may be offset by regular engagement in self-care. Self-care was enhanced by flexible scheduling, socializing with other PRS, working on self-esteem, and reminders from other PRS. Burnout may also be offset by finding a sense of meaning (i.e., inspiration) from work. Regular group supervision could be an effective avenue to discuss caseload and scheduling, access support, reflect on inspirations, and engage in exercises to enhance efficacy. Again, PRS training that includes focus on preventing burnout and accessing self-care is critical, but must be supported with regular, competent supervision.

Ideally, PRS and clients are well-matched on similar experiences, which may facilitate efficient relationship-building, and a sense of mutuality. This sample reported feeling very well-matched with clients and that clients generally opened up to them within 2–3 sessions. Although this study cannot test this directly, it may be, as one PRS stated, that feeling inspired by clients is a way to create strong relationships. Mutuality is created through PRS helping clients and clients inspiring PRS; and this inspiration, in turn, fosters a sense of purpose for PRS.

Findings suggest: (1) It is important for training to adequately cover how to maintain boundaries, assist clients with coping skills, prevent burnout and engage in self-care; and (2) The importance of supervision following training to reinforce these areas, and address ongoing matters that can arise (e.g., caseload, scheduling, support). Although the questionnaires and focus groups were not designed to specifically study PRS supervision, content touching on supervision was repeatedly discussed. Given that findings strongly suggest the crucial and pivotal role of regular and competent supervision, it is important that systems employing PRS have polices that attend to training and supporting supervisors. In addition, this area should be a focus of further research. Findings also suggest, for systems employing PRS, it is critical to attend to larger systems-level factors that properly support PRS including reimbursement rates, funding, and adequate public transportation. Attending to such training and supervision needs, and to funding stability may be pivotal in strengthening this important resource in community mental health settings.

The findings of the current study are consistent with prior work in PRS. Past studies have also noted funding concerns, inadequate supervision, importance of boundaries, and benefits to PRS in the work they do (Daniels et al., 2012; Kuhn et al., 2015). Since there is relatively little work in this area, such replication is important. However, this study makes a unique and important contribution in better understanding what elements of PRS training may be of particular need, the critical value of supervision, and the role that inspiration may play for both PRS and their clients. This study did not find overwhelming evidence for problems with co-workers and stigma of PRS themselves, as has been noted in prior work (Moran et al., 2012). This may be due to PRS becoming more broadly recognized as the field progresses in general, and/or because the particular system in which this study took place has done a relatively good job in educating healthcare providers on peer recovery. It is also possible participants did not want to critique co-workers in a public focus group setting.

Concerns about working long hours, funding, burnout and lack of supervision is not specific to PRS, nor is enjoyment of working on a team to assist clients and the need for self-care—indeed such themes arise in other healthcare professions (Acton & Malathum, 2000; Foster et al., 2019; Ray et al., 2013; Rossler, 2012; Volpe et al., 2014). Resiliency, which is the positive adaptation when facing stress and/or adversity, appears to offset burnout and enhance self-care for professionals in the healthcare field (Foster et al., 2019). Given that PRS are selected based on their own recovery, they may be particularly resilient. In this case, it may be important and fruitful to explore resiliency as an avenue to reduce burnout and encourage self-care during supervision. This deserves further research.

Limitations

There was a lack of diversity in the make-up of the research team. All researchers identified as women ($N=6$) and all were White, which may have deterred some people of color or men from participating in the focus groups. The sample was not diverse with respect to gender, race or ethnicity, and most participants were middle-aged. However, the diversity in participant experience (both in-training and certified) is a benefit to the study. Focus groups were also not organized by particular demographic groups. In the future, this separation might inspire more volunteers (who are comfortable talking with like others) and provide more in-depth context to the different experiences of PRS. The status (university researchers) as well as the gender and racial identities of the team may have also led participants to answer (or not answer) questions in certain ways. Assumptions about the researcher's goals and agendas can lead participants to respond in particular ways (Stewart et al., 2007). Moreover, the potential for group think or an unwillingness to speak negatively about peers or supervisors (especially in a work setting) are also limitations of focus groups (Stewart et al., 2007). The experiences of the research team members ranged widely from 1 to 20 years of experience in the mental health field and with qualitative research. To address this range, the team used regular research meetings for cross-training in both content and methods. Nonetheless, a team that includes even well-trained novices may be less effective than one composed exclusively of seasoned scholars.

Focus group participants were not separated by employees and supervisors, which might have impacted how candid

some respondents were about supervision. However, it should be noted that questionnaire data (collected privately) were fairly consistent with the qualitative findings. No follow-up was used to examine change in content over time; however, such follow-up was not necessary to examine benefits and challenges of PRS work and personal impact of the work on PRS. Comparisons cannot be made across systems as the sample was drawn from a single system employing PRS, although this system covered an entire state. In future work, researchers may seek to include more diverse team members when designing the study and consider separating participants by demographics in order to provide more context to the experiences of PRS.

Implications

PRS find much fulfillment in their work, although there are financial and other challenges associated with this work (e.g., assisting clients in learning coping skills, maintaining boundaries). These aspects of peer work can impact PRS personally, leading to burnout and necessitating self-care. However, this work can also inspire PRS. To sustain a functioning PRS workforce, systems must adequately fund PRS; proper training covering critical areas should be covered (e.g., assisting clients with coping skills, maintaining boundaries), and PRS supervision must be emphasized (e.g., supervisor roles and support for supervisors). PRS and other healthcare professionals identify similar concerns and benefits related to work including long hours, funding concerns, burnout, lack of supervision, enjoyment of team work to assist clients, and need for self-care. However, unique among PRS is that they are chosen expressly for their shared experience with often relapsing mental health/substance use conditions; and yet ironically, taking time from work to manage such conditions was viewed as potentially jeopardizing employment.

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