

# Certified Peer Specialist Roles and Activities: Results From a National Survey

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**Objective:** In 2001 Georgia became the first state to allow services provided by certified peer specialists (CPSs) to be reimbursed by Medicaid. Six other states have since followed Georgia's lead, with many others in the process of doing so. This study examined where CPSs work and what they do. **Methods:** CPSs (N=291) from 28 states completed an online survey. **Results:** CPSs primarily did their work within the agency rather than in the community and worked most often with individuals rather than groups. CPSs frequently provided peer support and focus on self-determination, health and wellness, hope, communication with providers, illness management, and stigma. They spent the least amount of time supporting people's family, parenting, dating, or spiritual relationships. **Conclusions:** CPS work settings and modalities varied greatly, although a core set of activities was identified. Implications for developing and refining CPS roles in the system are discussed, along with suggestions for additional training and supervision. (*Psychiatric Services* 61:520-523, 2010)

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Peer support initiatives have historically occurred outside traditional mental health services. They typically consist of self-help or mutual-aid groups or small, localized independent programs modestly funded by states and counties. A dramatic change occurred in 2001 when Georgia approved peer support services provided by certified peer specialists (CPSs) for Medicaid reimbursement. This pioneering event officially recognized experience in recovery from mental illness as a valuable source of knowledge and peer relationships as a powerful and unique source of support. It also guaranteed stable funding and brought peer support squarely within the system of care. An additional six states have since approved peer support as a Medicaid-reimbursable service; many more states are moving toward similar policies. On a national level, the Veterans Health Administration has also proceeded in hiring CPSs.

These efforts represent a milestone in mental health service delivery and are a concrete step toward system transformation as outlined in the President's New Freedom Commission Report (1). However, as these efforts gain momentum, many questions and concerns arise about the hiring of peers and embedding them within the mental health system. For example, lower wages for CPSs have been reported along with limited career paths; lack of supervision, support, desk space, and computers; and exclusion from team meetings and access to medical records (2). There is resistance in the mental health system to hiring CPSs (3), and there are concerns that

those who are hired are viewed as ancillary to those from more traditional mental health disciplines (4). Apart from one study in the Department of Veterans Affairs (3), there is little detailed information about the kinds of work that CPSs are doing; that study showed that CPSs were involved in the following activities: patient orientation, leading groups, completing intakes and screenings, treatment planning, helping veterans find housing, accompanying veterans to community activities, and advocating on behalf of patients to get needed services.

The purpose of this study was to enhance our understanding of CPS activities. The theoretical framework used is the notion of "behavior settings" espoused by Barker (5) to explain variability in human behavior across settings. Our hypothesis was that the activities of CPSs, just like those of other mental health providers, will vary across the settings in which they work just as, for example, the professional activities of psychiatrists vary among long-term institutional settings, inpatient hospital settings, case management teams, and private clinics. We focused on the extent to which CPSs provide individualized and community supports. We also explored the extent to which CPSs provide various types of supports. There is a great deal of interest, as well as confusion and concern, about this emerging behavioral health workforce. The results of this study will be of interest to funders, agencies, and programs in understanding how they are currently incorporating CPSs into the behavioral health system and will point to possi-

ble directions for modifying and further structuring CPS activities, training, and supervision.

## Methods

A brief survey was developed with input from a CPS. Participants were asked to identify the type of program in which they work and the percentage of their work time (up to 100%) they spend in activities at the agency or program site or in the community. They were then asked to estimate the percentage of time that they generally spend supporting people in groups or individually and working with families and with community members, employers, or others. Finally, respondents were asked to indicate on a scale from 1 (never) to 5 (always) how often they supported their peers in a number of specific areas.

Inclusion for this study was limited to CPSs who were currently working in a paid CPS position in the United States. The survey instrument was entered into Survey Monkey, an online survey vendor, which enabled persons with Internet access to complete it. Five respondents printed the survey and submitted it by postal mail. A written announcement about the survey was displayed on numerous Web

sites that target CPSs and was distributed on CPS and related electronic mailing lists. The survey was available online from June to November 2008; a total of 336 individuals responded in that period. Of these, 45 were excluded for any of the following reasons: they were not currently employed as a CPS, they were working as a CPS on only a voluntary basis, they were not living or working in the United States, or they did not answer questions about their work activities. The final study sample was 291. The survey was deemed to be exempt by the authors' institutional review board, and respondents read an informed consent statement and agreed that they understood it before completing the survey.

## Results

The final sample of 291 CPSs included individuals from 28 states. Of the 260 CPSs who responded to a question about their gender, 85 (33%) indicated that their gender was male, 172 (66%) responded that they were female, and three (1%) indicated that they were transgender. Of the 251 participants who disclosed their racial-ethnic identification, 198 (79%) indicated that they were white or

Caucasian; 29 (12%) black or African American; eight (3%) Hispanic or Latino; three (1%) Asian, Pacific Islander, or Hawaiian Native; three (1%) Native American; and ten (4%) multiracial. The average respondent had been employed as a CPS for a mean±SD of 23.8±22.8 months and had worked 29.6±11.5 hours per week. Of the 106 respondents who indicated "other" for the type of program they worked in, 102 provided a brief description of their program. Twenty-four of these were recoded into similar program categories already provided, and 33 were coded into four new categories: residential, education and advocacy, crisis services, and psychiatric rehabilitation. An "other" category was developed for those whose responses could not be coded and for when there were fewer than five respondents in the category.

Overall, CPSs spent almost twice as much time on site as in the community (59% compared with 33%) (Table 1). However, this varied greatly by program. Only those in case management programs spent more time in the community than at the program site. Those in more site-based programs, such as partial hospitalization programs, clubhouses, or

**Table 1**

Work location, modality of supports, and service recipients of 291 certified peer specialists<sup>a</sup>

Program	Location					Modality					Natural supports				
	N	At an agency or on the phone		In community, in client's residence, or in transit		N	Supporting people in groups		Supporting people individually		N	Working with families		Working with community members, employers	
		M	SD	M	SD		M	SD	M	SD		M	SD	M	SD
Overall	257	59	30	33	29	254	25	27	48	30	254	4	7	8	11
Case management	50	42	25	53	26	48	15	18	61	26	48	5	9	8	9
Partial hospitalization or day program, inpatient, or crisis	28	76	34	13	22	28	38	29	43	29	28	4	7	6	11
Vocational rehabilitation or clubhouse	21	75	29	17	22	21	32	29	47	28	21	3	6	4	7
Therapeutic recreation or psychiatric rehabilitation	7	49	29	39	31	7	36	39	44	36	7	1	4	7	10
Residential	10	49	25	40	21	10	4	7	75	25	10	3	6	11	11
Drop-in center	20	80	21	12	14	19	41	24	37	19	19	3	7	8	10
Education and advocacy	15	65	24	19	25	15	27	25	26	27	15	4	9	14	26
Independent peer support program	62	56	28	37	30	62	22	28	51	32	62	3	6	7	9
Other or could not be coded	44	58	28	36	28	44	22	25	38	31	44	6	8	11	11

<sup>a</sup> Values are mean percentages. Certified peer specialists were asked what percentage of their work time they typically spent in the activities indicated.

drop-in centers, as well as those involved in education and advocacy, spent 65% or more of their time at the agency and less than 20% in the community. CPSs devoted almost twice as much time supporting peers individually as in groups (48% versus 25%), although there was some variability across programs. Those working in case management and residential programs provided a significant amount of individualized support, followed by CPSs in stand-alone peer support programs and employment-oriented programs (vocational rehabilitation and clubhouse). CPSs in the other programs provided nearly equal amounts of group and individual supports. CPSs across all programs spent relatively little time working with families or other community members compared with the time spent supporting their peers individually and in groups.

Peer support was by far the most prevalent activity provided by CPSs (4.48±.77 on a scale of 1, never, to 5, always), followed by encouragement of self-determination and personal responsibility (4.26±.88). Other prevalent supports provided were health and wellness (3.87±.93), addressing hopelessness (3.84±1.08), communication with providers (3.68±.99), illness management (3.62±1.13), addressing stigma in the community (3.56±1.13), developing friendships (3.51±1.05), leisure and recreation (3.25±1.14), education (3.16±1.12), transportation (3.06±1.28), and developing wellness recovery action plans (3.04±1.31). Less central supports, with means below 3 (indicating “sometimes”), included family relationships (2.95±1.11), employment (2.94±1.06), citizenship (2.83±1.15), spirituality and religion (2.74±1.12), developing psychiatric advance directives (2.27±1.18), parenting (2.14±1.15), and dating (1.74±.98). A factor analysis of these supports was conducted, which resulted in a stable five-factor solution (6). No consistent differences in activities were seen across programs.

## Discussion

Overall, our findings indicate that CPSs spent almost twice as much time at their agency site as in the

community and almost 50% of their time working with peers individually. One concern was that agencies hiring CPSs would view them as capable of providing supports only in groups, given the strong self-help and mutual-aid group history of peer support. Relatively little time was spent working with family members or those in the community who could provide key “natural supports” outside the mental health system. We also identified great variability overall in CPS activities. More frequent activities included the provision of peer support, understood as a sharing of personal experiences and provision of mutual aid, encouragement of self-determination and personal responsibility; a focus on health and wellness; addressing hopelessness; assistance in communications with providers; education about illness management; and combating stigma in the community. These activities are all directly related to the recovery principles from the Substance Abuse and Mental Health Services Administration (7). Other activities were not addressed as often—employment, citizenship, spirituality and religion, developing psychiatric advance directives, parenting, and dating. These are areas in which CPSs are uniquely knowledgeable and qualified because of their own personal experience and understanding of the importance of these areas to recovery.

Although not definitive because small samples in certain programs prevented statistical analysis, our results nonetheless appear to support the influence of settings on CPS activities. Given that CPSs spent almost twice as much time in their agencies as in the community, this agency-based effort was even more extreme for those who work in partial hospitalization, inpatient, or crisis settings; vocational rehabilitation centers or clubhouses; drop-in centers; or education and advocacy programs. CPSs in case management programs were the only ones who spent more time working in the community than at their agency. Intuitively, these results are consistent with what might be expected for all providers who work in these programs. Moreover, although

most CPSs’ efforts are spent working with individuals, those working in residential programs—and case management programs to a certain extent—stand out in this regard. CPSs working in drop-in centers were the only ones to provide more supports in groups than individually. No patterns were detected in working with family members and those from the larger community because of the limited amount of activity with these groups. One clear conclusion is that CPS activities, like other disciplines in the behavioral health workforce, are assorted and vary greatly by the setting in which the CPS works. In other words, a CPS is not a CPS is not a CPS.

Study limitations include our inability to verify that respondents were indeed CPSs. We are also unable to claim that the sample is necessarily representative of CPSs as a group, and the study may include unknown biases. Furthermore, we reasonably presumed that most information submitted was accurate but still vulnerable to the threat of a respondent’s mischievous behavior or deception. The list of activities was based on input from CPSs and good knowledge of CPS activities but was not exhaustive. For example, peers assisting other peers in finding housing is likely a major support activity that was not included. It is not known how the exclusion of this and other supports may affect the results. Finally, small samples in certain programs prevented us from conducting statistical analyses. This limited us to judging program differences on the basis of our impressions rather than on statistical analyses. Nonetheless, we attempted to be cautious in our judgments.

These findings have important implications for this emerging workforce. They demonstrate the great variability in CPS roles and activities that foundations and agencies should consider as they continue to move forward in bringing CPSs into the system. However, such range also presents a challenge for CPS training. Evidence shows that CPS training is effective (8–10), yet current training is 80 hours or less and may cover only the basics—usually the

core activities that CPSs are found to universally provide across all settings. Greater attention should be paid to providing effective supervision and continuing education focused on the specific setting in which a CPS works and on additional supports that CPSs can provide. One potential area that is deserving of greater attention in training and continuing education is a focus on areas where CPSs might have the most insight into their importance for leading a meaningful life in the community, such as employment, spirituality and religion, citizenship, and dating. These are all areas that are not currently a central focus of CPS work.

This study did not address the extent to which the supports provided by CPSs are effective. However, the findings suggest that research aimed at advancing the evidence base about the effectiveness of CPS-delivered services must keep in mind that the CPS designation is akin to a professional discipline, like psychiatrist, psychologist, or social worker, and that CPSs engage in a wide variety of activities in different settings that may result in different effects. Any study of CPS effectiveness must take this range of activities into consideration when selecting outcomes of interest. Such research will go a long way in validating investments in CPSs as important members of the behavioral health workforce.

## Conclusions

As with any other emerging workforce, CPSs will face challenges. Their work needs to be accepted as worthy of pay rather than as a volunteer effort. Moreover, there is pressure to develop national CPS training, professional standards, and ethical standards. Standards will be hotly debated because standardization raises dilemmas on many dimensions—professional versus layperson, professional or academic knowledge versus experiential knowledge, and traditional mental health service delivery approaches versus approaches based on the ethos of self-help and mutual aid. The National Association of Peer Specialists and statewide CPS organizations are taking action to address these issues and to recognize the varied CPS roles and uniqueness of peer support.

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## References

1. Achieving the Promise: Transforming Mental Health Care in America. Pub no SMA-03-3832. Rockville, Md, Department of Health and Human Services, President's New Freedom Commission on Mental Health, 2003

2. Chinman MJ, Lucksted A, Gresen R, et al: Early experiences of employing consumer-providers in the VA. *Psychiatric Services* 59:1315–1321, 2008
3. Chinman M, Young AS, Hassell J, et al: Toward the implementation of mental health consumer provider services. *Journal of Behavioral Health Services and Research* 33:176–195, 2006
4. Salzer MS, Mental Health Association of Southeastern Pennsylvania Best Practices Team: Consumer-delivered services as a best practice in mental health care delivery and the development of best practice guidelines. *Psychiatric Rehabilitation Skills* 6:355–382, 2002
5. Barker RG: *Ecological Psychology: Concepts and Methods for Studying the Environment of Human Behavior*. Palo Alto, Calif, Stanford University Press, 1968
6. Salzer MS: Certified peer specialists in the United States behavioral health system: an emerging workforce; in *Mental Health Self-Help: Consumer and Family Initiatives*. Edited by Brown LD, Wituk S. New York, Springer, in press
7. National Consensus Statement on Mental Health Recovery. Rockville, Md, US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2005. Available at [mentalhealth.samhsa.gov/publications/allpubs/sma05-4129](http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129)
8. Salzer MS, Katz J, Kidwell B, et al: Pennsylvania certified peer specialist initiative: training, employment, and work satisfaction outcomes. *Psychiatric Rehabilitation Journal* 32:293–297, 2009
9. Hutchinson DS, Anthony WA, Ashcroft L, et al: The personal and vocational impact of training and employing people with psychiatric disabilities as providers. *Psychiatric Rehabilitation Journal* 29:205–213, 2006
10. Ratzlaff S, McDiarmid D, Marty D, et al: The Kansas consumer as provider program: measuring the effects of a supported education initiative. *Psychiatric Rehabilitation Journal* 29:174–182, 2006