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Organizational dynamics at a peer respite: A focused ethnography of an emergent strategy

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**ABSTRACT**

A focused ethnography aimed to understand organizational dynamics affecting a state-funded pilot peer-operated respite in the Southwest region of the United States of America. Findings from 8 interviews with program directors and peer staff (N = 12), 2 focus group discussions with peer staff (N = 8), and field notes from 198 hours of participant observation indicated that staff experienced many organizational demands from the traditional public mental health system and different imperatives associated with the peer respite model as an emergent strategy. Within a context of resource scarcity and a lack of integrated social services, organizational issues related to program sustainability, peer staff accommodation, and peer staff’s confusion regarding the program’s intent became evident. Findings identified a gap in the literature regarding the peer respite model’s approach to hosting guests experiencing homelessness and confirmed other research on peer labor that indicates further systemic support is needed to improve work conditions. Implications of these findings and the organizational limits of a peer respite within resource-poor environments are also discussed.

**KEYWORDS**
Emergent strategy; homelessness; systems transformation; peer respite; peer support

**Introduction**

In 2003, the Bush Administration’s New Freedom Commission on Mental Health directed mental health providers to promote recovery in their services, marking a paradigm shift in public mental health care from the view of mental illness as an often chronic condition towards a more “optimistic” approach that noted recovery is possible for most people who have experienced mental health crises (The Carter Center Mental Health Program, 2003). In general, recovery values tend to include the promotion of hope, self-empowerment, social support, flexible service delivery, meaningful activities, and a range of peer services—mental health support provided by those with lived experience of mental health struggles and/or psychiatric histories (Crowley, 2000; Deegan, 1988; Jacobson, 2004). Despite laudable efforts to define and implement these values, the recovery paradigm has remained...
contested and its operationalization varied throughout the United States of America (McLean, 2003; Myers, 2015). Some critics, such as historian and psychiatrist Joel Braslow, question if recovery-oriented practices have merely served as a rhetorical flourish on neoliberal economic policies to further erode social welfare programs through the privatization of formerly public mental health care and the emergence of new expectations regarding an individual’s “ability” to recover from mental crisis (Braslow, 2013; see also McWade, 2016). Nevertheless, peer support services as an emergent strategy within the dominant structure of U.S. public mental health systems have also grown in scope and range, as changes to federal and state funding have led to an increase of recovery-oriented programs (Chinman et al., 2014).

Within recovery-oriented and peer-provided services, peer-staffed crisis residential programs have gained popularity over the last two decades and now include 12 peer-run respites in the United States and a dozen more peer-operated respites, typically supported and overseen by public mental health systems (Ostrow, 2010; PeerRespite.net, 2018). Both models provide voluntary, recovery-oriented support in a short-term residential facility for people experiencing mental health crises (Ostrow & Croft, 2015). However, peer-run respites are characterized as independent nonprofits with a majority of peers on the board of directors, while peer-operated respites (also known as hybrid respites) are commonly defined as programs in which the director and staff identify as peers yet the parent organization that controls it is not peer-run (National Empowerment Center, 2009).

Given the limited number of both quantitative and qualitative studies on peer respites and on mental health crisis respite care more broadly (Grant & Westhues, 2012; Jeon, Brodaty, & Chesterson, 2005), this study aims to fill a gap in the literature by describing organizational dynamics between a public mental health system and its peer respite, as described by peer staff. A randomized control trial comparing a peer-run respite to clinical treatment found that service users at the peer respite reported higher satisfaction in their treatment (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008). A quantitative study of guest service user outcomes at a peer-operated respite in Santa Cruz, California demonstrated a reduction in psychiatric hospitalization rates by 70% and increased social engagement (Croft & Isvan, 2015), and other quantitative studies indicated peer respites’ efficacy in reducing psychiatric hospitalization rates among specific populations of service users (Bouchery et al., 2018; Burns-Lynch & Salzer, 2001). In her ethnography of peers working at a peer-operated respite in the Northeast, anthropologist Lauren Cubellis (2018) described the many challenges peer staff face in offering forms of care that require deep vulnerability. Cubellis argued that the emotional labor performed by peers involves a recognition of shared experiences, precarity, and loss, under the backdrop of structural inequities...
that guests experience; and she detailed instances in which peers indicated a sense of alienation, re-traumatization, hopelessness, and futility in the work they performed in light of systemic issues that perpetuated poor mental health, homelessness, and resource scarcity in a large urban environment. Similar occupational stressors—such as compassion fatigue and burnout—are common to professionals in community-based mental health services, particularly among workers who meet criteria for experiencing psychological distress (Rossi et al., 2012); See also (Ahmed, Hunter, Mabe, Tucker, & Buckley, 2015; Brodwin, 2013; Walker & Bryant, 2013).

In addition, this paper seeks to contribute to the literature on organizational challenges associated with piloting emergent structures as a part of mental health systems transformation. As Grant and Westhues (2012) described in their process evaluation of a mental health crisis respite service in Ontario, Canada, emergent structures in public mental health, such as those associated with recovery-oriented care, often take root uneasily and co-exist in parallel with dominant structures and paradigms in traditional mental health care. Three years after an initial needs assessments which resulted in the creation of a crisis respite, Grant and Westhues documented mission creep at a crisis respite from a recovery-oriented approach towards a more “rule-based” approach, what they considered to be a typical mode of governance within the dominant, traditional structure. Their study analysis noted the “contradictions, shifts, or interactions” between these approaches, which tended to favor the dominant structure (p. 49; See also Grant, 2010; von Bertalanffy, 1950). In a similar vein, our focused ethnography sought to identify sources of tension between the dominant structure of a public mental health system and the emergent structure attempted in a peer respite, as identified by peer staff. To this end, this article describes study findings and considers broader implications associated with the organizational limits of a peer respite within a fragmented system of social services.

**Method**

**Research site**

Lighthouse (a pseudonym) operates in an affluent neighborhood lined with old live oak trees and centrally located near several public transit routes, museums, hospitals, and other social services within a sprawling city in the American Southwest. Opened in 2016 as the first peer-operated respite in the state, Lighthouse aims to foster a home-like environment, to serve “guests in crisis who might otherwise be faced with traditional psychiatric hospitalizations,” and to facilitate a “supportive, non-judgmental setting by Peer Staff who have lived experience in recovery from mental illness,” according to pamphlet literature posted on the Local Mental Health Authority (LMHA)’s website. It can house up to 9 guests, with 3 single bedrooms, 3 bedrooms that
could be shared by 2 guests, 2 large living rooms, a front porch and covered patio area, a kitchen, dining room, a locked staff room where records were kept, 2 small offices for administrators, and a laundry room.

Under the LMHA’s oversight, Lighthouse is staffed by 2 program directors–1 program director who oversees several crisis residential facilities within the LMHA and 1 program director who oversees daily operations, 1 executive assistant, 1 peer team lead, and 12 peer staff (for the majority of our fieldwork, Lighthouse was understaffed with only 10 peers). Except for the executive assistant, all staff identified as having lived experience of psychiatric histories and/or substance abuse. This supervision schema is one which Darby Penney (2018) defines as a peer staff model—one that is typified by employees who are “expected to disclose their psychiatric histories and serve as role models for people they serve,” and whose relationships are characterized by set hierarchies among supervisors, staff, and service users (p. 3). Such relationships are typically found within traditional mental health systems, in contrast to the horizontal relationships that make up what Penney terms “peer-developed peer support,” mutual aid practices that emerged from grassroots activism and advocacy in the United States during the 1970s (p. 1–2).

**Data collection**

A focused ethnography, a research methodology common to nursing studies, allowed us to gather rich qualitative data within a relatively short time-frame, and participant observation gave us a deeper understanding of daily operations and enabled us to triangulate data (Cruz & Higginbottom, 2013; Knoblauch, 2005; Stahlke Wall, 2014). Fieldwork spanned 3 months during Spring 2018, throughout which time we logged 198 hours of participant observation. On average, the co-authors spent 20 hours collectively at Lighthouse each week and conducted participant observation during different times of the workweek and over weekends. Our presence allowed us to interact with research participants in an informal manner; observe interactions among guests, staff, and management; and gain a sense of norms, daily activities, and the general milieu. Participant observation also involved having coffee with guests, engaging in group meetings with peers and guests, preparing and eating meals together, cleaning the kitchen area, and socializing in common areas. In addition, we attended 2 monthly staff meetings, observed 9 daily groups led by peers, participated in 6 community events hosted, and joined 1 conference call featuring 2 staff members. Written informed consent was obtained from all research participants. No financial compensation was given to research participants, as directed by the LMHA’s Institute Review Board that approved this study.

Peer staff (who ranged in age from late-30s to late-50s) were fairly representative of the metropolis’s population and came from diverse ethnic,
class, vocational, and gender backgrounds. Less than half of them had a bachelor’s degree. Both program directors had their master’s in social work. All staff members were invited to participate in the study, and 3 peer staff declined to participate in formal interviews with us—although all consented to our presence at Lighthouse and contributed to the research project in other ways. Semi-structured interviews and focus group discussions (ranging from 30 minutes to 2 hours in length) were recorded digitally and later transcribed by undergraduate research assistants. Onsite notes and summary field notes were written after each period of ethnographic observation, which averaged 4 hours each visit. Other data sources included Lighthouse protocol developed by program managers and peer staff and agency-approved pamphlet literature about the peer-operated respite.

Both researchers had prior working with qualitative data from peer respite; and both had prior experience with the city’s fragmented mental health system—AB from assessing 52 mental health facilities in the metropolis and other areas in the United States, and EF from long-standing connections with many local nonprofit organizations and from serving as a primary caregiver to a family member enrolled in services at the LMHA. The authors had also built a strong working relationship with one of the program directors over the course of a year prior to conducting the study.

In order to understand organizational dynamics that structured Lighthouse’s operation within the LMHA, we generated preliminary codes independently through an open coding process. For the purposes of this article, 8 interviews with program directors and peer staff (N=12), 2 focus group discussions with peer staff (N=8), and field notes were reviewed carefully. Open codes were compared, confirmed, and consolidated into a list of initial codes through a series of discussions between researchers throughout our time conducting fieldwork and following data collection (Charmaz, 2006). Codes about competing agendas regarding Lighthouse’s place as an emergent strategy within a dominant structure were further categorized, with a focus on challenges at a macro-level (systemic constraints), meso-level (conflicting approaches between LMHA and program directors’ goals for the program), and micro-level (program director-to-peer and peer-to-peer interactions). Processes of theoretical sampling and memo writing were used to further define and elaborate the boundaries of such categories and themes with regard to program sustainability, the management of peer staff on issues such as accommodation, and interpersonal dynamics among all staff. Remaining differences in codes were resolved through discussion until consensus was obtained. Two months after the close of fieldwork, preliminary study outcomes—including emergent themes—underwent a member-checking process with Lighthouse staff to improve internal validity (Flick, 2007). This iterative process enabled us to generate theory on a peer respite’s place as an emergent structure within
a dominant structure—the implications of which we explore further in the discussion section.

**Ethical considerations**

Given the sensitive nature of guest stays and peer labor at Lighthouse, we did not want our presence to become overly intrusive, or subvert the organization’s goals to foster a peaceful environment for guests, nor did we want to cause additional stress to peers in our interactions with them (Ostrow & Croft, 2015). We thought deeply about strategies to minimize our impact as social researchers while exploring key issues to peer labor. Indeed, as we began to reach theoretical saturation within our thematic categories during the tenth week of fieldwork, we started to receive questions from peer staff about our timeline for the completion of the data collection (Charmaz, 2006). We interpreted such questions as a sign of their anxiety regarding our presence, and we decided to end our fieldwork slightly earlier than planned in order to minimize our impact on operations and respect research participants’ desire for privacy.

In detailing instances in which research participants’ actions created ethical quandaries, we view these challenging situations as necessary moments of reflection for user/survivor activists, peers, program directors, and leaders in psychiatric rehabilitation and social work. As stakeholders grapple with the realities of peer employment and the struggles to make inclusive spaces for peers within rather sedimented and highly bureaucratized mental health systems, attention must be paid to the complexities of peer labor in peer-operated respites.

**Findings**

This study found that staff identified a lack of public housing and integrated social services as contributing to organizational tensions between dominant structures in the public mental health system and an emergent structure at the peer respite. Such tensions resulted in issues related to 1) the program’s sustainability as dependent upon maintaining high occupancy rates, which was often at odds with its overt goal to serve as an alternative to psychiatric hospitalization, and 2) a disconnect between the public mental health system’s rules-based approach to program management and program directors’ attempts to create a therapeutic space for guests and staff alike. These findings confirmed scholarship regarding the entanglement of psychiatric and housing crises (Hopper, 2002, Luhrmann, 2007), and indicated the need for evaluation metrics that capture the unique aspects of peer support, beyond those commonly used in public mental health systems (Penney, 2018). These findings also identified a gap in the literature on peer respite models with regard to whether or how to support
guests experiencing homelessness. In addition, at an interpersonal level, this disconnect between dominant and emergent strategies made it difficult for peers to understand program goals and program directors’ approaches to peer respite management. Moreover, peer staff confusion regarding program directors’ covert, even subversive goals for Lighthouse resulted in some peers feeling a sense of differential management on the part of program directors and a sense of discrimination from fellow peer staff. This finding adds to the literature by revealing instances of conflict among peers with regard to differing perspectives on equal vs. equitable accommodation and furthers calls for the supportive employment of peers (Wandersman et al., 2008). See Table 1 for a diagram of tensions between dominant and emergent approaches at Lighthouse.

**Theme 1: Systemic pressures on public mental health services**

Within the metropolis where Lighthouse is located, the number of people experiencing extreme homelessness—often characterized by living in emergency shelter or somewhere not intended for habitation—is estimated to be 4,000. Over the last several decades, efforts were made to build coalitions to address homelessness and to increase access to social services for people experiencing homelessness within a fragmented social services system. However, large gaps in continuity of care remain for vulnerable populations. For example, patient medical histories are not readily shared among service providers in the public

**Table 1. Chart of tensions between dominant and emergent structures.**

<table>
<thead>
<tr>
<th>Macro</th>
<th>Fragmented Social Services</th>
<th>Lack of Public Housing</th>
<th>Emerging Structure of a Peer Respite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meso Dominant Structure of LMHA</td>
<td>Competing Agendas Program Goals</td>
<td>Alternative to psychiatric hospitalization</td>
<td>Model does not address homelessness</td>
</tr>
<tr>
<td>Need to maintain high occupancy</td>
<td>← →</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proxy temporary housing</td>
<td>← →</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Micro Program Supervisors</td>
<td>Rule-based management</td>
<td>Recovery-oriented management</td>
<td></td>
</tr>
<tr>
<td>Equal Accommodations, based on LMHA guidelines</td>
<td>← →</td>
<td>Equitable Accommodations, based on peer staff’s strengths and needs</td>
<td></td>
</tr>
<tr>
<td>Peer Staff</td>
<td>Felt ill-equipped to work with guests accessing Lighthouse</td>
<td>Received peer support training to work with people solely experiencing a mental health crisis who are housed</td>
<td></td>
</tr>
<tr>
<td>Perceived inconsistent management and favoritism, when program directors made peer staff accommodations</td>
<td>← →</td>
<td>Recognized program directors’ attempts to recognize differing needs among staff and to create a therapeutic, equitable work environment</td>
<td></td>
</tr>
</tbody>
</table>
health system, the public mental health system, the local jail, or among local public and private hospitals treating people who are hospitalized for psychiatric needs. Within this larger context of resource scarcity and a lack of integrated social services, the LMHA operates a number of crisis residential services, including a step-down unit for people discharged from a psychiatric hospitalization and other residential units which provide intensive, structured environments for people in need of stabilization. The vast majority of service users at these crisis residential services are experiencing some form of homelessness—a factor which severely limits their potential for recovery from mental distress.

Theme 2: Tensions between covert and overt goals

**Program directors’ subversive goals as emergent strategies**

Explaining the program’s sly origins, one program director described the status of all psychosocial services (including crisis residential services) as subservient to medical (biopsychiatric) services within the bureaucracy and outlined challenges associated with implementing Lighthouse as an emergent strategy within the dominant system:

I recognize that there are definitely problems associated with what I would describe as a hybrid peer respite—one, that is, that operates within the confines of a community mental health center, because there are often competing interests that have to do with things like medication and hospitalization. There’s a competition between psychosocial issues and medical issues. And it is nowhere more clearly seen than in a model like this. I can’t begin to tell you when we implemented this model what a nightmare it was to argue our case [to upper-level medical administration] …

Given that program directors were often subject to the purview of upper-level medical administrators, their subordinate status within the agency made Lighthouse’s future contingent upon bureaucratic sanction.

Within this context, Lighthouse program directors received support to write a grant proposal for Lighthouse within a short amount of time; and in the proposal, they indicated that the program’s goal was to serve as an alternative to psychiatric hospitalization, even though they presumed from their past experiences working in the LMHA’s crisis residential services that the majority of Lighthouse guests would also be experiencing homelessness in addition to mental distress. They did so, in part, because they recognized that this funding could enable new employment opportunities for peer staff, provide vital temporary housing for guests who were often enrolled in LMHA services, and serve as a more open, empowering, and potentially kinder space for guests than the highly structured environment of other crisis residential services. A program director described the need to make an overt claim about the program’s goals to serve as an alternative to psychiatric hospitalization, with the covert understanding that it
would serve as a proxy homeless shelter, step-down unit, or other form of temporary housing. In an interview, one program director further explained this rhetoric decision:

I'll just be candid—I was homeless for a while; and my experience then and now is that the vast majority of people who are homeless have serious mental illnesses of some sort, undiagnosed maybe, or certainly untreated. So there’s a serious homelessness problem in the city—there are scarce resources for homeless people. When I wrote the grant proposal, it was with the understanding that we would admit homeless people here even though some of the [peer respite] models specifically exclude homeless people due to placement issues. So my theory was that if you’re going to be a true respite, you give people a break from whatever their circumstances are—that’s what respite means, you give them a rest. And so, if they’re sleeping on a cardboard slab, then you give them a little break from their cardboard slab, so maybe they can take a few moments and collect their thoughts and try to get something organized a little bit in their lives. So I have been the culprit on the homelessness issue. I wrote it into the grant proposal, I will not yield on it—not now, not ever, because that’s where mentally ill folks are … So yeah, I know, we whine because, where are we going to place them? And we get on fire with this issue of we have to place them, blah blah. No, you don’t. Who said that, where did that rule get written? You give them a respite—from whatever their circumstances are—you give them a break.

Moreover, program directors believed they would have outside support for continued renewal through the LMHA, because, as one of them stated, “The state and other community mental health centers view it [Lighthouse] as a shiny new toy that we have, and nobody else has.” Their decision to move forward with implementing the program, despite the many “competing interests” at the LMHA and calculated risks they would have to make, reflects the difficult compromises program directors perceived were necessary to enable emergent rhetorically-savvy approaches. In short, they decided that opening a peer respite as an innovative practice within the LMHA was well worth its potential use (and covert goal) to serve as proxy temporary housing.

After they were awarded the two-year state pilot grant, program directors soon found themselves tasked with the need to rapidly implement funds; and during the planning phase, upper-level administration within the LMHA created certain constraints for operations protocol at Lighthouse—constraints which significantly limited their autonomy to develop the program in response to local needs and assets and to train its staff accordingly. For instance, Lighthouse was expected to open before many peer staff had received state training as certified peer support specialists. When they did receive the week-long training and a supplemental training in Intentional Peer Support, peer staff indicated that their training provided somewhat divergent, even contradictory perspectives on the nature and purpose of peer staff in relation to service users and the LMHA; and both were consistently geared towards providing
peer support for housed people who were experiencing a mental health crisis. Overall, peer staff felt ill-equipped to host and provide peer support for guests experiencing a crisis of homelessness. Nevertheless, news of Lighthouse quickly spread within the homeless community, far faster than it traveled through the LMHA; and correspondingly, the very first guest who checked in was experiencing homelessness.

Having created traditional parameters for Lighthouse’s evaluation, LMHA upper-level administration soon informed program directors that Lighthouse’s sustainability beyond the two-year pilot funding was contingent upon proving its utility and place within the LMHA, through maintaining high occupancy rates and promoting “flexible” admittance. Ironically, this pressure to achieve high utilization rates was somewhat at odds with the LMHA’s own public statements regarding preferred criteria for guest admittance—including county residency, stable housing, independent living skills for individuals with developmental disabilities or who were experiencing an extreme mental state, and no active drug or alcohol use (as defined by 72 hours of sobriety prior to admittance). Interestingly, the LMHA’s tacit policy aligned well with program director’s covert goals to support people experiencing homelessness and led to a general admittance of guests primarily experiencing a crisis of homelessness. This uneasy alliance between the LMHA’s need to maintain high occupancy and program director’s covert goals to provide respite services for those experiencing homelessness exemplifies how the dominant structure of program evaluation at the LMHA (based on the volume of service utility) took precedence over emergent, overt goals for the peer respite to serve as an alternative to psychiatric hospitalization.

Strategically furthering this uneasy alliance between the LMHA and the program, Lighthouse program directors also indicated that their actions to promote such “flexible” admittance of guests served as a strategy to raise the profile of the program among fellow administrators within the LMHA. Within the rather siloed bureaucracy, many LMHA administrators were slow to educate their caseworkers and social workers about Lighthouse’s existence and purpose as an internal resource. Furthermore, garnering favors from upper-level administration through the “flexible” admittance of guests experiencing crises of homelessness served as an important strategy to gain social traction, ingratiate the program within the agency itself, and garner recognition as a useful innovation within the LMHA. Even with this big tent approach to guest admittance, program directors and peer staff found that it would take Lighthouse a significant amount of time to reach a high census rate (full occupancy), due to a general lack of awareness about Lighthouse in the community and in the LMHA.
Peer confusion about Lighthouse’s overt and covert goals

Over the course of our fieldwork, we found that peer staff often felt a sense of confusion about Lighthouse’s overt goal to serve as an alternative to psychiatric hospitalization and its applied work as temporary housing, and in our conversations with them, peer staff did not seem to understand the ways in which program directors’ covert goal to provide respite to people experiencing crises of homelessness aligned uneasily with LMHA’s pressure on program directors to maintain high occupancy rates. Indicating his own confusion regarding Lighthouse’s purpose and its failure to galvanize internal recognition within the LMHA or external recognition in the community, one peer told us:

I don’t know why, after a year and a half of this place being open, people still don’t know about it in the community. People within the LMHA—employees—don’t understand how it is meant to be used. I guess I’d say we have a branding problem, or folks just don’t know about us. Caseworkers [are] being overworked and wanting to dump folks on us, cause they have so many people they’re trying to help, and they’re trying to stop the bleeding. In terms of like, ‘Hey, please, I need to know if you have any beds!’ Well, it doesn’t work like that, you need to have your client call us, we need to have a conversation. The fact that [LMHA] caseworkers, some of ’em anyway, don’t know [our purpose] … it’s kind of frustrating.

From this quote, it became evident that the peer did not understand that, indeed, Lighthouse was working as program directors covertly intended—as a bandage for the bleeding wound of homelessness in the city, as tied to mental distress.

Likewise, peer staff were often concerned about program directors’ decisions to accept guests who they saw as not being an ideal fit for Lighthouse’s services. Some peers felt as though many of their efforts to lead daily empowerment groups and other therapeutic activities were missed by guests primarily experiencing crises of homelessness (because so many of them left early in the morning to access local social services). Similarly, guests were often confused about the Lighthouse’s intent and often assumed that peer staff ought to operate like case managers and help them access needed social welfare programs. Describing guests’ perceived misunderstanding of Lighthouse’s function, one peer stated as follows:

No employee here is gonna be making phone calls for them. We’re not meant to hand out resources anymore, or resource contact information. If that’s part of our lived experience, we can share it with people, but the onus is very much on each individual guest, or at least that’s how it’s meant to work. So it’s a different experience, and every now-and-again we have people leave who don’t have that next step squared away, and feelings are hurt. There are misunderstandings. Like, “Why didn’t y’all do anything for me?” Well, we did, but we can only do as much as you’ll let us, and there are some constraints on us too.
Given guest and peer staff’s confusion about the program’s intent, peer staff often felt like their efforts to offer peer support for guests experiencing homelessness and to empower them to make their own decisions had little impact on guests’ mental health recovery and their search to find more permanent housing.

During our fieldwork, we observed a guest whose stay typified the concerns that many peer staff held towards serving people primarily experiencing crises of homelessness: Moe, a former merchant marine in his late 30s, told one of us that he had come to Lighthouse after being discharged from a psychiatric ward. He had an intellectual disability and was experiencing homelessness, which led some peer staff to help him find transitional housing during his stay. He did not seem comfortable using public transit, which made it difficult for him to gain access to nearby social services throughout his stay. With the prospect of homelessness looming in the near future, Moe’s mental health worsened, and he became increasingly quiet, withdrawn, and unkempt. When he did speak, his speech pattern and trains of thought were difficult to follow, and he was not able to contact various housing services on his own behalf. He told staff that he had a “scholarship” to enter the LMHA’s crisis residential housing program, but Lighthouse staff knew that there was no scholarship for the free program and that beds there were already filled for the coming night. After several days of extending his stay, peer staff were forced to tell him that he could no longer stay at Lighthouse and that they would transport him to a nearby shelter, an act which caused those involved distress and anxiety. On the day he left, peers talked to each other in hushed tones to determine who would take him to the men’s shelter downtown, while another peer was tasked with ensuring that his belongings were packed in a trash bag and taken downstairs.

Although they agreed that most guests were able to find some form of housing following their stay at Lighthouse and that transporting former guests to shelters was not the norm, peer staff tended to see checkouts like Moe’s as being a systemic failure. Peer staff blamed “idealistic” program management for accepting a guest who had an intellectual disability and was not able to find temporary housing within a short time frame—both attributes could have disqualified him for admittance under the LMHA’s preferred criteria. Indirectly, peer staff also blamed Moe for not making the necessary calls to find housing. Peer staff did not believe Moe’s admittance fit within the program’s overt goals to serve as an alternative to psychiatric hospitalization, while peer directors, in turn, justified their decision to accept him into Lighthouse as a practice of covert goals to provide temporary relief for the mental distress of homelessness and to meet the LMHA’s expectations to fill beds. The gap between staff expectations of their roles to facilitate an innovative, recovery-oriented program and the reality on the ground, created a sense of confusion about their role within Lighthouse and a sense of futility,
which anthropologist Paul Brodwin (2013) describes as “a sense of ineffectiveness or the felt incapacity to produce the desired result” (p. 69).

**Theme 3: Interpersonal tensions in dominant and emergent governance**

Resource scarcity, a lack of integrated services, and uneasy alliances between the LMHA and program directors’ goals for Lighthouse affected peer staff in profound ways. However, many peer staff tended to attribute occupational stressors to a perceived lack of clarity on the part of program directors’ management and to challenging interpersonal dynamics among peer staff, rather than to systemic failures; namely, some peer staff perceived poor management on the part of program directors—not only for their flexible admittance policies—but also for their approach to staff accommodations, which in turn created divisiveness among peer staff. With regard to both issues, the disconnect between the LMHA’s rules-based, equal approach to program governance and program directors’ attempts to create a therapeutic, equitable, and recovery-oriented work environment became apparent.

**Peer staff accommodation**

Within the dominant structure of the LMHA, full-time peer staff were given a set number of sick days and paid leave, among other benefits, and expected to follow rules that were common to all LMHA employees who provided mental health services. This exacting approach to the equal treatment of peer staff was often at odds with program directors’ more organic method to recovery-oriented, person-centered, equitable accommodations for staff—which took into consideration a peer’s unique mental health needs and sought to accommodate unique mental differences. In contrast to the LMHA’s standard employment practices, program directors believed it was a part of their responsibility as employers to contribute to peer staff’s recovery, to retain well-qualified peer staff, and to take a person-centered approach to therapeutic workplace accommodations that attempted to adapt to peers’ changing needs.

In turn, this tension between equal and equitable accommodation practices led to some peers’ perception of program directors’ favoritism of some peer staff over others, inconsistent management, and blurred boundaries between professional supervision and friendships between managers and peer staff. Referring to the program directors’ approach to program governance, a peer staff member explained as follows:

[Program directors are] just so indecisive; and it’s so frustrating. You can never get an answer, and you never know, like, what was good today is bad tomorrow. And
then it's good again, and then you're in trouble for it. And you're like, "What?! Like this is something you encouraged me to do, and now I'm being written up for it." And I am really confused—I would like someone to be ... more consistent.

Recognizing peer staff confusion regarding their attempts at equitable accommodations for staff, one program director stated as follows:

In trying to be person-centered, in the spirit of what we're doing, there have been agreements or accommodations [for peer staff] that I've made early on. So, for several people, when we hire them, even in the interview, we discuss what they're able to do, what they're not able to do, what their limitations are. So, if I make a decision to hire them based on that, then OK, we're gonna do this. Now the rest of the staff aren't privy to whichever specific hiring circumstance [lived experience of psychiatric history with which] we brought other people on, so it builds resentment. "Well, why does that person get this, and that person gets this?" So we try to work with each person and then we try to accommodate along the way.

This individualized approach to recovery-oriented employment was associated with blurred professional boundaries for both program directors and staff. For instance, one peer staff told us that she called a program director in the dead of night to ask for support while her partner was going through "mental health breakdown" for the first time. The program director stayed with her on the phone and helped her figure out options for her partner to receive mental health care. Such willingness to go above the role of an employer made the program director deeply respected, even beloved, among some peer staff, who took it upon themselves to defend this "authentic" approach to upper management. Still, program directors often found themselves in confounding roles, at times serving as confidantes, therapists, and employers to peer staff.

Despite frequently benefiting from equitable accommodation practices, peers often viewed administrators’ decisions regarding hiring and firing staff, reprimanding poor work behavior, or creating employee guidelines as rather arbitrary—based on mood or temperament—and not a part of a larger paradigm shift to promote recovery through premising individual needs over a more standardized approach. Peer staff’s desire for greater clarity in decision-making processes was not lost on program directors, one of whom stated as follows:

We've had some [peer] staff with significant issues that have happened, and that's always created a stir, always created some resentment. Sometimes some [peer] staff have said things to me like, "Oh well, you favor that person more than that person, because they went to the hospital, and you kept their job." Or, I've been told by other supervisors, "Oh, that's your pet project, because, you know, we would've fired that person." So, maybe I work hard to keep staff and retain them. Not because of retention purposes—because that person is a person; and I try to give them as much room as possible. That's helped sometimes, that's helped that person through that crisis, but ... there have been times, maybe I've ... maybe I did too much. But I still did it within the scope of an employer.
Maintaining employee privacy while feeling pressure to justify operational decisions often placed program directors within double binds. Program directors attempted to adapt to peer staff’s needs, even while doing so sometimes created a sense of distrust and misunderstanding among other peer staff.

**Discrimination among peer staff**

At times, peer staff caught between the dominant structure of the LMHA’s employment practices and the emergent strategy for recovery-oriented employment at Lighthouse turned against each other and pointed to fellow peer staff for contributing to a challenging work environment. On occasion, peer staff faced discrimination on the part of other peer staff for their need to take sick leave unexpectedly due to mental health issues; and because the program was understaffed at the time, peer staff were directly impacted by each other’s mental health struggles, with some peers having to take on additional shifts—including night shifts—in order to remain in accordance with protocol set by the LMHA for a minimum of two peer staff to be present for every shift.

One peer staff member characterized interpersonal conflicts at Lighthouse as a matter of entitlement on the part of some colleagues:

> In one word I think there’s one camp that feels … entitled. That’s my impression—entitled. They are used to getting … the schedules they want, getting the accolades they want, and the way they approach work appears like it is entitlement, you know? It feels like they want to come in on their shift and [have] everything already be done. There’s no dish in the sink, there’s no bed to be made, there’s no intake. And it’s like, that’s kind of what you do! [laughs] What else is there, if you don’t want to do those things? And then the other camp is people who feel like the entitled camp are getting away with everything, they’re getting everything their way and we’re left doing the work and we’re left getting fussed at if we leave anything for this camp to do so …

Listing the sources that contribute to negative interpersonal dynamics among colleagues, another peer similarly stated their workplace grievances in what follows:

> Some of my coworkers not really being motivated, in-fighting or cliques, hostile workplace, and no direction or discipline from management as far as bad behavior. It pains me to see people be able to get out scot-free from [interpersonal conflicts with] other co-workers, and then being able to fall back on “I have a diagnosis,” or “I’m having a tough time at home,” “I’m going through some things.”

Judging another peer staff member’s inability or unwillingness to perform mundane tasks at Lighthouse also served to further a sense of stigma against certain staff
members, and perpetuated the belief that job performance measures should be based on workers’ productivity, regardless of their mental health needs.

Likewise, in a focus group discussion, one peer staff member said that she knew that she would experience some discrimination as a peer working in a clinical setting, but that experiencing stigma from colleagues with similar lived experiences felt more painful in a way because they were supposed to better relate to each other’s struggles. She went on to say, “I love this [job]. Don’t get me wrong—it’s not the house. It’s not the guests. It’s my coworkers that I have an issue with … I came in thinking it would be, we’re coming together, we’re a team, we’re coming to fight off the stigma. And I get here, and it’s just like, everybody uses your diagnosis against you.” Given the diverse mental health needs of staff, the dynamism of people’s capacity to perform the manual and emotional labor of peer work, and the program’s understaffing issue, interpersonal tensions created from the need to adapt and accommodate each other’s needs over LMHA’s standard approach to equal treatment of all employees frustrated even the most dedicated peer staff members and often pitted one against the other.

**Discussion**

**Systemic pressures**

This study suggests that peer respites—as an emerging structure within dominant structures—faces organizational challenges that make it difficult for peer respites housed within public mental health systems to operate in accordance with the model’s original intent to serve as psychiatric hospital diversion. Regarding structural factors that contribute to organizational tensions, this study confirms the need for public housing development as tied to community mental health promotion, both for guests and the peer staff serving them (Cubellis, 2018). It confirms the need to further distinguish peer respites from temporary housing programs, step-down units, and other crisis residential units, as articulated by mental health policy researchers (Ostrow & Croft, 2015). Alternatively, given that poverty and poor mental health are often complex and deeply entangled issues (Mills, 2015), public administrators interested in opening peer respites must consider how to address issues of homelessness, with the recognition that in a public mental health system, guests who seek out services from a peer respite will likely be experiencing homelessness or some form of housing precarity. Moreover, this study points to a gap in the literature between the peer respite model and its use within public mental health systems; and further research is needed on publicly-funded peer respite models in order to understand the utility of this model for populations experiencing homelessness and other forms of extreme resource scarcity. If peer respites are found to be an efficacious,
meaningful intervention for people experiencing homelessness, further questions emerge regarding appropriate training and roles for program managers and peer support specialists working with this service user population.

**Program evaluation of an emergent strategy**

With respect to evaluation standards, this study adds to scholarship that indicates making direct comparisons between traditional mental health services and peer services may obfuscate the unique aspects of peer support and create unintended pressures to meet demands for high usage rates (Penney, 2018). Rather, as other studies indicate, public administrators must create deliberate strategies to align public funding for recovery-oriented programs with peer values related to community capacity-building, empowerment, and self-determination (Anthony, 1993). In this case, the LMHA’s need to evaluate Lighthouse in terms of its other crisis residential programs created undue pressures on program directors to maintain high occupancy rates in order secure renewable funding for the program. This is not to say that recovery-oriented practices should be separate from evidence-based practices, but as Davidson, Drake, Schmutte, Dinzeo, and Andres-Hyman (2009) note, thoughtful incorporation of measures such as first-personal accounts and techniques in participatory research within evidence-based program evaluation may ensure that service-users have greater options for mental health support. Such evaluation techniques may further integrate recovery-oriented practices within evidence-based literature and also sharpen divides between peer work and clinical work in a productive way that allows peer work to remain distinctive within public mental health systems transformation.

**Interpersonal tensions**

As other studies indicate, organizational context greatly affects peer staff’s perception of their role, and improving organizational culture and strategies in service delivery may help peers feel more supported in their vocation (Clossey & Rheinheimer, 2014; Frost, Heinz, & Bach, 2011; Grant & Westhues, 2012; Solomon, 2004). More specifically, setting aside sufficient time to build community awareness, involving local stakeholders in program and evaluation design, creating professional networks of peers within the county, training peers to meet the anticipated needs of service users, and creating feedback loops for corrective improvements in program implementation may strengthen the quality of services provided (Pope, Cubellis, & Hopper, 2016). In addition, greater institutional support—such as creating a pool for on-call night staff, developing more consistent scheduling practices, and streamlining hiring and termination procedures—may
prove helpful in reducing sources of interpersonal tension among peers and fostering a more positive work environment.

As Lighthouse matures as a pilot program and staff develop strategies to resolve or mitigate personal conflicts and systemic pressures, peers will continue to adapt to the stresses commonly associated with implementing a new program (Pope et al., 2016). This study contributes to the literature indicating that much confusion remains about peer labor and role ambiguity regarding their placement within mental health systems (Colson & Francis, 2009; Cronise, Teixeira, Rogers, & Harrington, 2016; Miyamoto & Sono, 2012; Moran, Russinova, Gidugu, & Gagne, 2013). A recent national survey of peer employment found that peers experience challenges associated with role ambiguity, inadequate training, and insufficient recognition for their efforts on the part of peer supervisors (Cronise et al., 2016); and a literature review of studies related to peer labor similarly noted issues associated with role ambiguity, unclear professional boundaries, low wages, and disclosure of peer status (Miyamoto & Sono, 2012). A metasynthesis of qualitative findings on peer labor in adult mental health services also reported difficulties associated with discrimination among non-peer staff, poor compensation and hours, and need for improved training and supervision practices (Walker & Bryant, 2013). Interestingly, qualitative interviews with peers employed at peer-run organizations revealed similar challenges associated with role ambiguity, accommodating peers, precarious interpersonal relationships, and loose work structure as major occupational issues facing peers (Moran et al., 2013). More broadly, our findings indicate that peer workers often face similar occupational stressors to other front-line workers in public mental health systems who are overwhelmed by population needs in resource-scarce environments (Besterman-Dahan, Lind, & Crocker, 2014; Bowles, 2016; Brodwin, 2011; Tartakovsky & Kovardinsky, 2013).

To our knowledge, this is the first study that notes ways in which forms of discrimination take shape explicitly among peer staff at a peer-operated respite, although other studies have described instances in which peers adopt organizational dispositions in ways that reify hierarchical power dynamics between staff and services users (Grant & Westhues, 2012; Myers, 2015). Perhaps because peer staff’s professional identities were often entangled within their ability to provide peer support for guests—and occasionally for their coworkers, many felt a sense of confusion, burnout, even futility, when tasked with the challenge of encouraging guests experiencing homelessness to find transitional housing, or when simply asked to hold space for guests while they spent several days asleep or at rest (Cubellis, 2018; Mancini & Lawson, 2009). Given this dilemma, a strategy to maintain their professional identity as peers may have been to pivot their attention away from guests as sources of work stress and towards criticism to colleagues and program directors, who were similarly constrained by the effects of resource scarcity and a lack of integrated social services within the city. Increased
supervision and consistent dialogue between staff and peers supervisors may mitigate the effects of role ambiguity, perceived discrimination, and accommodation issues associated with organizational tensions. This point is corroborated by a survey of the membership of a national peer professional organization, which found that peer supervisors’ consistent availability was associated with role clarity and job satisfaction among peers employed on treatment teams at community mental health centers (Davis, 2015). Broadly, greater attention to the interpersonal dynamics at play among peer staff may provide insight into coping mechanisms and structural support needed to promote a sense of meaningful work and optimism at peer-operated respites.

**Study limitations**

The limited sample of peer staff interviewed for this study and the program directors’ strong support of our presence at Lighthouse may have led to selection bias on the part of peer staff who may have felt as though our agenda was closely aligned with program directors’ interests. In addition, the 3 month period in which we conducted fieldwork and gathered interview data was rather brief for ethnographic research, though not uncommon for focused ethnographies. With more time and support, creating a Community-Based Participatory Research project and involving peers with the research design may better align researchers with the peer value of mutuality and shared responsibility (Wallerstein & Duran, 2008; Ostrow & Croft, 2015). In addition, involving those with lived experience of the mental health system within data collection, analysis, and the writing process may improve the depth of information and response rate of research participants and contribute to increasing the rigor and quality of the evaluation process (Croft, Ostrow, Italia, Camp-Bernard, & Jacobs, 2016).

**Research implications**

Administrators, clinicians, and researchers should note tensions associated with public mental health systems’ imperatives to treat a large number of service users within their implementation of peer-staffed recovery-oriented programs. Challenges to implementing pilot programs such as Lighthouse are particularly pronounced in circumstances in which peer training and protocol are rather piecemeal, varied, and implemented after the program opened. Moreover, situations in which a primarily source of guests’ mental distress is homelessness create confusion regarding appropriate roles for peer staff and place an undue burden on them to serve as case managers or social workers—roles which peers are not trained to perform. Further research is needed to determine which characteristics of guest service users would make them a good fit for peer-operated respites, how peer respites within public mental health systems ought to address guests’ needs
with regard to housing, and strategies to improve the recruitment, hiring, and supervision of peer staff.

Despite unique challenges surrounding the implementation of emergent structures within public mental health systems, understanding organizational tension associated with the adoption of emergent practices in mental health support allows peers, providers, and administrators to articulate and address competing agendas between public mental health systems and recovery-oriented programs, so that peer support provided at peer-operated respites can be as meaningful and beneficial as possible. Findings from this study can lead to more thoughtful, comprehensive strategies to design such programs within LMHAs, tailor peer staff training to anticipated guest service user demographics and needs, accommodate peer staff needs, raise community awareness about program resources, and foster a sense of camaraderie among coworkers.

Notes

1. The crisis respite model was first piloted in the late 70s by psychiatrist Loren Mosher, who supervised and studied a 12-bed house staffed by peers and clinicians (Mosher & Menn, 1978).

2. Those who use such services are referred to as “guests” as opposed to “patients” in order to reflect the explicitly nonclinical therapeutic aspects of such facilities and their focus on mutuality, respect, and shared responsibility (See Croft et al., 2016).

3. In response to the closure of many public housing projects throughout the city and sustained efforts to criminalize homelessness, public-private partnerships enabled some development of permanent, supportive housing through a tax-credit voucher system; and like other cities in the United States, waitlists for these services were quite extensive.

4. Despite the slow recognition of Lighthouse within the LMHA, many if not most referrals eventually came from the LMHA, law enforcement on homeless outreach teams, social workers from local public hospitals’ emergency services, and former guests to those who were also experiencing homelessness, potential guests and those who referred them to Lighthouse—most of whom seemed to view the organization primarily as transitional housing.

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