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Peer Perspectives: Expectations and Satisfaction with Certified Peer Specialist Services

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Abstract

Certified Peer Specialists (CPSs) have experienced recovery from mental illness and are employed in the mental health system to provide peer support. The importance of CPS services is that support is provided by individuals with shared experience of the disabling power of mental illness. The present study is an initial examination of expectations and satisfaction with CPS services using the expectancy-disconfirmation theory as a conceptual framework. Attendees of the 2009 Kansas Recovery Conference were asked to volunteer for an interview about CPS services, in which 26 CPS service recipients and 146 non-recipients completed interviews. Kruskal-Wallis analyses found no significant differences between expectations of benefits before or after receiving CPS services. Significant positive correlations were found between satisfaction and perceived benefits of CPS services. Results of the study provide support for the expectancy-disconfirmation theory, indicating positive initial perceptions of CPS services, and suggesting that peers have consistent expectations of and experiences with CPS services.

Keywords: peer support, service expectations

Introduction

An integral component of recovery for individuals in the mental health system is peer support, which provides an opportunity for several individuals to identify with one another based on shared experiences (Davidson et al., 1999, Solomon, 2004). Peer support allows an individual to develop a helping relationship based on the unique and powerful shared experience of mental illness within the framework of recovery from mental illness (Deegan, 2006; Mead, Hilton, & Curtis, 2001). Within mental health, it is important that peer support occurs

between individuals who have shared experience as it is the essential aspect of peer support (Penney, 2008).

Although the term "consumer" is commonly used in the mental health literature, this paper will utilize the term "peer" when referring to individuals who receive mental health services. This term is relevant because of the role played by both the peer support professional and the individual who is receiving that help. Using "peer" instead of "consumer" allows us to view the individual who receives peer-driven mental health services as a part of the recovery journey that is separate from mental health services themselves. Recovery in mental health refers to restoring meaning to life and regaining control of decisions about the direction of one's life (Davidson et al., 2010; Powell, 2009; Sabin & Daniels, 2003).

History of Peer Support

Peer support has been documented as a part of the mental health system since 1838 when Richard Paternoster organized a campaign of "ex-inmates" in England to reform the mental health system by providing volunteer-based peer support and advocating for mental health reform (Deegan, 2006; Hervey, 1986). Use of peer support by trained people in recovery from mental illness began in the United States in the 1920s, when Harry Stack Sullivan recruited young men who had recovered from psychiatric disorders to work as aides on his unit of a psychiatric hospital. Due to his personal experience with a mental health diagnosis and recovery, Sullivan believed that the aides would similarly be well prepared to work with their peers because of their experiences with recovery (Davidson, Rakfeldt, & Strauss, 2010). Consequently, Sullivan established a new possibility of integrating peer support into the mental health system through a paid staff position. The acknowledgement of peer support as an essential component of treatment and recovery, however, began to be accepted starting with the time of deinstitutionalization in the 1960's (Davidson et al., 1999; Davidson et al., 2010).

Ideas about peer support resulted in a power shift where the helper no longer had "professional" power over the helpee, but where helper and helpee had equivalent standing and both benefited from the relationship. One of the results was an increase in dignity for the helpee who now had a role model for recovery, and the possibility that the helpee could become a role model for others. Sullivan reported recovery rates of around 80% with peers whom received peer support, which encouraged Sullivan's integration of peer support and community involvement (Davidson et al., 2010).

Peer Support and the Recovery Movement

Peer support has been more recently identified in the Recovery Movement (in which the goal is recovery from mental illness) as an important way to help peers recover from mental illness (Davidson, Chinman, Sells, & Rowe, 2006). Many positive outcomes have been associated with peer support in mental health, such as decreased time spent in hospitals, reduced symptoms, broadened social networks, increased hope, and improved self-image and personal well-being (Chinman, Weingarten, Stayner, & Davidson, 2001; Davidson et al., 1999). Furthermore, peer support has been associated with both objective and subjective improvements in quality of life (Felton et al., 1995). Peer support provides a sense of community, support, empathy, and understanding, which results in the positive outcomes that have been described (Chinman et al., 2001).

Peer support can be found in informal or formal settings in the mental health system. Naturally occurring peer support is an informal and unstructured way to share concerns and resources. Each participant takes on a role in the supportive relationship to assist the peer (Davidson et al., 1999). Peer support can also be found in consumer-run organizations (CROs), which are typically outside the formal mental health system. CROs are structured settings created by and for peers, resulting in naturally-occurring peer support and staff-encouraged peer support (Brown et al., 2008). Peer support can also be provided through a paid position in the formal mental health system, providing an alternative to the traditional treatment approach to mental illness (Davidson et al., 1999).

Certified Peer Specialists

A Certified Peer Specialist (CPS) is a person who is employed to provide peer support in the mental health system (Mead & MacNeil, 2006). A CPS provides a role model to help a peer make sense of his or her recovery journey, provides hope, and is able to guide the peer toward mental health recovery (Mead & MacNeil, 2006).

Georgia became the first state to create the role of CPS and received Medicaid reimbursement starting in 2001 (Fricks, 2005). Georgia was able to successfully implement a CPS program that made the mental health system more recovery-oriented (Sabin & Daniels, 2003). The success of the Georgia program led to the use of the Georgia program in other states including Kansas which established a Medicaid-billable CPS program in 2007 (Swink & Grant, 2009). Although the CPS program in Kansas is a relatively recent addition to the mental health system, there are over 60 CPSs employed in 26 of the 27 community mental health centers across the state (Daniels et al., 2010).

Satisfaction with Services

Higher satisfaction with mental health services has been found to result in lower readmission rates and increased follow-up with services (Druss, Rosenheck, & Stolar, 1999). The time of greatest risk of dropout with mental health services is found to occur during the first two visits, which is complicated by the low engagement of care that may occur in a medical setting. Self-help group attendance, however, has been found to increase participation in mental health services (Olfson et al., 2009). CPS services provide a personal connection between peers (Mead, Hilton, & Curtis, 2001) that may work to increase follow-through with services. Consequently, high satisfaction with CPS services can be expected to provide many of the same benefits that high satisfaction provides with other services. Expectancy-disconfirmation theory provides a conceptual framework to examine the expectations and satisfaction with CPS services.

Expectancy-disconfirmation Theory.

Expectancy-disconfirmation theory was developed by Oliver (1980) to explain consumer satisfaction with a product or service. The theory suggests that we form initial expectations about a service and we compare the actual outcome with our expected outcome. Consequently, we evaluate the service as better than or worse than our expectation, leading to a satisfaction or lack of satisfaction with the service. Oliver uses the term "disconfirmation" in his theory to refer to discovering that an expectation is not true. He explains that when the expectation is disconfirmed in a positive direction, or is better than expected, the individual's satisfaction will be strongest. Satisfaction will be slightly lower when the expectation was confirmed. Satisfaction is lowest when disconfirmation occurs in a negative direction, or is worse than expected. The expectancy-disconfirmation theory has been a useful theory in understanding outcomes in other areas of health care and has been shown to support the relationship between expectations and satisfaction (Hills & Kitchen, 2007; Zwick, Pieters, & Baumgartner, 1995).

Research Questions

One aspect of CPS services that has received little attention in the literature is client satisfaction with services. The present study provides an initial examination of peers' perceptions of CPS services. It provides an understanding of the expectations about the service and how those expectations relate to satisfaction with the service. More specifically, the study addresses the following:

1. What are the expected benefits of CPS services as identified by individuals who receive CPS services and individuals who have not received CPS services?
2. What are similarities and differences in expectations between those who have received CPS services and those who have not?
3. How do expectations regarding CPS services relate to satisfaction with CPS services among individuals who have received CPS services?

Methods

Participants

Interviews. Participants in this study included adult mental health peers attending the 2009 Kansas Recovery Conference in Wichita, Kansas. The Kansas Recovery Conference is the largest conference for peers in the United States (Wichita State University, 2008) and was attended by 898 peers in 2009. A total of 172 individuals chose to participate in the interviews. Of the participants, 38% (n=66) were male and 62% (n=106) were female. Seventy-three percent identified as Caucasian, 5% identified as African American, 1% identified as Asian, 2% identified as Hispanic, 5% identified as Native American, and 13% identified as other or combination of more than one racial categories. Average age of participants was 45 years old with ages ranging from 19 to 67 years of age. Twenty-seven percent of participants (n=47) were married, 6% (n=10) were divorced, 4% (n=7) were widowed, 37% (n=63) were separated, 5% (n=8) were cohabitating, and 22% (n=37) reported never being married. At the time of the survey, 9% of participants (n=15) reported working full time, 24% (n=41) reported part-time employment, and 65% (n=112) reported being unemployed. Employment information was not obtained for four participants.

Focus groups. Participants of the focus groups were adult peers who attended the 2009 Kansas Recovery Conference. Twenty-one individuals participated in the focus groups, with 12 in the "not receiving services" group and 9 in the "receiving services" group. Seven males and five females were in the focus group for peers who had not received CPS services, while four males and five females were in the focus group for peers who had received CPS services.

Procedure

Human subjects approval was obtained through the Institutional Review Board at Wichita State University (WSU). Research was conducted through the WSU Center for Community Support & Research in Wichita, Kansas.

Interviews. Individuals were informed of the opportunity to participate in the interviews through a description in the Kansas Recovery Conference Program and by researchers at a booth in the exhibitor's area of the conference. All peers were welcomed to participate in the study.

Prior to conducting interviews, individuals were provided written consent for participation in the study. After participants signed the consent form, the interview was administered in a private area and took approximately 15 minutes.

Focus groups. Upon completion of the interviews during the first day of the Recovery Conference, peers were invited to participate in one of two focus groups. Information about the focus groups was also present at the research booth in the exhibitor's area of the conference. Due to limited space, participants were asked to sign up for a time at the research booth if planning to participate. One focus group was conducted for individuals who had not received CPS services and one focus group was conducted with individuals who had received CPS services. No more than two participants from the same mental health center participated in a focus group to ensure a more representative group.

Two researchers co-facilitated the focus groups and a third researcher took notes. Each researcher reviewed the facilitation guide, informed consent, CPS description forms, and procedures to ensure congruence of procedure. Prior to conducting the focus groups, written informed consent was obtained from all participants. Individuals were encouraged to provide as much information as they were comfortable with sharing. Digital voice recorders were used for the transcription of the focus group discussion. Focus groups took 60 minutes to complete.

Instruments

Interviews. The CPS Services Interview was designed to examine the use of CPS services among peers. All participants completed the same demographics section. Participants were given one of two different forms of the instrument depending on previous use of CPS services.

Demographics. The demographics section of the interview collected general demographic information from participants regarding age, gender, zip code, marital status, race/ ethnicity, and employment status. Income sources were identified by asking individuals to indicate the types of supplemental income that were received.

Receiving CPS services This interview was designed for peers who had or were currently receiving CPS services. Twenty-six individuals completed the "receiving services" interview, which included questions about outcomes of services and satisfaction with services. The "outcomes of services" and "satisfaction with services" scales were taken from the Mental Health Statistical Improvement Program (MHSIP) consumer survey, which was developed to assess the quality of mental health services through consumer perceptions of care (CMHS, 1996).

Perceived benefits of services

The "outcomes of services" scale of the MHSIP was developed to measure the perception of outcomes of care. Three of the items were omitted for a total of 12 items. Two omitted items measured outcomes associated with medications instead of direct services, and one omitted item measured outcomes with employment. Example items for the scale include "I am better able to control my life," "I have become more effective in getting what I need," and "I deal more effectively with daily problems." Responses were provided on a five-point Likert scale from 1 being 'Strongly Disagree' to 5 being 'Strongly Agree'. Wackwitz (2000) reported alpha levels of .94 for the "outcomes of services" scale.

Satisfaction with services

The "satisfaction with services" scale was a combination of items from the satisfaction, access, and appropriateness domains of the MHSIP. All three questions from the general satisfaction domain were used, two questions from the access domain were used, and five questions from the appropriateness domain were used. This scale was modified to measure perceptions of satisfaction with care with CPS services. Wackwitz (2000) reported a .88 alpha level on the general satisfaction subscale, a .81 alpha level on the access subscale, and a .94 alpha level on the entire appropriateness subscale. Example items for this scale are "I like the services that I receive from the CPS program," "I would recommend the CPS program to a friend or a family member," and "If I complain, the CPS will still treat me well." Responses were given on a five-point Likert scale of 1 being 'Strongly Disagree' to 5 being 'Strongly Agree'.

Not receiving CPS services

An alternate version of the interview was created for peers who had not received CPS services. One hundred

forty-six individuals completed this interview.

Potential benefits of services

Potential benefits of receiving CPS services were measured by using the outcomes scale from the MHSIP consumer survey (CMHS, 1996). Wording from the original scale was changed to reflect the hypothetical situation of possible benefits of receiving CPS services. Each statement was prefaced with the phrase "If I received CPS services" and was followed by a statement from the original scale. An example question from this scale is "If I received CPS services, I would deal more effectively with daily problems." Responses were given on a five-point Likert scale from 1 being 'Strongly Disagree' to 5 being 'Strongly Agree.'

Focus groups. The focus group for peers who received CPS services was designed to get more information about the nature of CPS services and satisfaction with the services. Questions were included about types of services provided by the CPS, what was working well, and barriers for getting services. Benefits of CPS services were discussed during the "what is working" section when participants were asked the question, "How do CPS services help you?" Researchers asked this as a general question and allowed participants to drive the conversation based on what was identified as important.

The focus group for peers who had not received CPS services included sections on peer support in the mental health system, understanding of what CPS does, potential benefits of CPS, and barriers to getting CPS services. During the potential benefits of peer support and CPS services section, participants were asked, "How do you think CPS services would benefit you?" Researchers allowed the participants to guide the conversation based on what elements were considered important and did not offer any suggestions about potential benefits.

Results

Focus Groups

Analysis of the responses from the focus groups was conducted by three researchers. Focus groups were transcribed and researchers themed statements to capture meaning. These were then grouped into overall themes, and a description of each theme was done by looking at original statements in each grouping and developing concepts.

Participants in the "receiving CPS services" focus group were asked the question, "How do CPS services help you?" which generated the themes of social interaction, guidance, and personal enhancement. Specific concepts for social interaction include encouragement, involvement in activities, decreased isolation, active care from CPS, internal support, and a different quality of mental health care. The theme guidance included specific concepts of mentoring, counsel, feedback, interaction, and shared experience. The theme personal enhancement included specific concepts of self-esteem, empowerment, understanding, and feelings of normality and acceptance.

Participants in the "not receiving CPS services" focus group were asked the question, "How do you think that CPS services would benefit you?" Researchers identified two main themes, including quality care and hope. Specific concepts for quality care include individualized care, attention, increased time, availability in crisis, better care, acceptance, comprehensive care, companionship, and personal support. Specific concepts for hope include investment in recovery, actual recovery, and being prepared for life possibilities.

Interviews

Expectations of CPS services for both groups of peers were examined by looking at the Potential Benefits scale from each group. Initial analyses revealed that data were not normally distributed. In addition to being unable to meet assumptions of a normal distribution, the group sizes were different with 26 individuals who had re-

ceived CPS services and 146 individuals who had not received CPS services. Therefore, to determine if there were differences between the groups, a Kruskal-Wallis test was conducted. The test, which was corrected for tied ranks, was not significant on any of the items (see Table 1).

Table 1

Potential Benefits for Peers

Potential Benefits	Received CPS (N=26) Mean	Not Received CPS (N=146) Mean	χ^2	*p*
I have become more independent.	4.31	3.86	3.35	0.07
I deal more effectively with daily problems.	4.46	4.3	1.77	0.18
I am getting along better with my family.	3.38	3.85	1.73	0.19
I do better in social situations.	4.27	4.08	1.23	0.27
I am better able to control my life.	4.23	3.99	1.12	0.29
I feel better about myself.	4.35	4.17	0.64	0.43
I can deal better with people and situations that used to be a problem for me.	4.19	4.12	0.48	0.49
My housing situation has improved.	3.54	3.36	0.32	0.57
My symptoms are not bothering me as much.	3.85	3.77	0.28	0.6
I am better able to deal with crisis.	4.04	4.19	0.22	0.64
I have become more effective in getting what I need.	4.23	4.15	0.07	0.79
I do better with my leisure time.	4.19	4.08	0.04	0.85

Guided by expectancy-disconfirmation theory, analyses were conducted to assess the level of similarity of expectations and satisfaction between those 26 individuals who had received CPS services. First, overall satisfaction for CPS services was reported to be high (M = 4.58, SD = 0.70). To examine the relationship between expectations for CPS and satisfaction with CPS services, correlational coefficients were computed between items of the Potential Benefits scale and the total satisfaction score, which was a sum of the satisfaction items. Using the Bonferroni approach to control for Type I error across the 12 correlations, a p value of less than .004 (.05/12 = .004) was required for significance. The results of the correlational analysis presented in Table 2 show that 8 out of the 12 correlations were statistically significant and were greater than or equal to .56. Signi-

ficant correlations included items about improvements in social situations, $r(24) = .79$, $p < .001$, independence, $r(24) = .77$, $p < .001$, getting what is needed, $r(24) = .73$, $p < .001$, dealing with daily problems, $r(24) = .71$, $p < .001$, dealing with problematic people and situations, $r(24) = .69$, $p < .001$, self-esteem, $r(24) = .62$, $p = .001$, life control, $r(24) = .60$, $p = .001$, and family relationships $r(24) = .56$, $p = .003$.

Discussion

Expectations and Satisfaction

Satisfaction with mental health services is an important element of outcomes of services. As satisfaction with services increases, readmission rates decrease and follow-up with the service increases (Druss et al., 1999). High levels of overall satisfaction with CPS services suggest that this new service is promising and may result in higher levels of follow-through with mental health services. High satisfaction and increased follow-through is important for mental health centers as they look at the value of the new position. It is also valuable to the peer, who will be more likely to benefit from peer support if the peer has high satisfaction levels. Satisfaction is also impacted by expectations about the service. As indicated by the expectancy-disconfirmation theory, the expectations that an individual has for a service will influence the satisfaction after receiving the service (Oliver, 1980). As found in this study, the expectations about CPS before peers receive the service are not significantly different from the experiences with CPS after receiving the service. The consistency with the expectations and actual perceived benefits of CPS indicate that individuals are receiving the service that they expect. According to the expectancy-disconfirmation theory, satisfaction should be fairly high because the expectations of the service are being met.

The results also demonstrate that satisfaction with CPS services increases as the perceived benefits with the eight items that had significant correlations increase. The significant correlations included social situations, increased independence, getting needs met, dealing with daily problems, dealing with problematic people or situations, self-concept, life control, and family. These items relate to the benefits previously identified by peers in the focus groups, such as personal enhancement, hope, and social interaction. Since these were significantly correlated with satisfaction, the areas identified by peers as areas of potential benefit may be of greater importance when looking at satisfaction with the service. The four items that were not significantly correlated (leisure time, symptoms, deal with crisis, and housing) were not related to any of the areas identified by peers in the focus groups about potential benefits. This finding illustrates that peers do not associate these areas with expected benefits of CPS services. Meeting the expectations that were associated with CPS services seemed to be related with overall satisfaction.

Benefits of CPS

An initial look at the expectations regarding CPS services was identified by a discussion of peers in focus groups. Expectations about the benefits by peers who had not received CPS services included two main themes: quality care and empowerment. When discussing quality care, peers expected increased personal attention from CPSs, which was identified as a need that was lacking in current services. This included more individualized care, personal attention, and more time with the peer than other providers. One individual stated, “They have more time to spend than your case manager might.” Other comments suggested that the CPS would provide better and more comprehensive care to peers while serving as a companion and source of personal support. Peers also thought they would be more available in times of crisis because “they’re always there if you need somebody to talk to.” The theme of hope of recovery was also found in the discussion by the focus group of those who had not received CPS services. Individuals expected CPSs to encourage recovery and preparation for different life possibilities. “You are actually gonna find recovery and succeed through your life.”

When peers who were in the “receiving CPS services” group were asked about benefits, the focus group discussion centered around three themes: social interaction, guidance, and personal enhancement. More specific-

ally, improvements in social interaction among the peers who had received CPS services were reported. The CPS helped peers identify enjoyable activities and encouraged peers to get out of their home to increase social interactions. "Sometimes they literally open the front door," which provided the support needed and showed the caring nature of the CPS. Peers identified this as a more active form of mental health care. "What if they not only tell you you're not alone but let you know you're not alone? I don't know if there's a difference. There is to me." The actions and forms of support identified by peers were identified as care with a different quality from other service providers in mental health systems.

Another area of emphasis in the focus group discussion of benefits of CPS services was guidance in the form of peer counseling, mentoring, and even by simple feedback. This guidance allows peers to become more reflective in their own thoughts. One woman said, "Mine bounces suggestions back off of me and suggestions I make too. She listens to me and says, 'well this is what you said.' And I said that? Hmm, well better start listening to yourself, girlfriend." Additionally, CPSs were able to assist peers in interpreting their own thoughts from a recovery framework.

Some cases, you may even have problems interpreting what's going on in your own head. So things like paranoia and manic depression screw around with that process. So, consequently, the thing that I see is, from my perspective, having somebody to bounce ideas off of is very important.

As can be seen, peers identify a reflective and interactive guidance as a benefit provided by a CPS.

The theme of personal enhancement was also identified as an important benefit of CPS services. A unique aspect of this theme includes feelings of normality and acceptance. Peers often feel marginalized and defined by their diagnosis. Services provided by a CPS allow the peer to step outside of the role as a mental health patient and provides an opportunity to find acceptance (Mead, 2003). One peer simply said, "they don't see you as different." The notion of normalization was a theme across much of the conversation in this focus group, which suggests this is a unique and important element provided by CPSs.

Peers also identified components of personal enhancement that included enhanced self-esteem. "I get confidence" was a response by one woman about the benefit of working with a CPS. Another peer responded by saying "it makes me feel better about myself so it gives me better self-respect." The pride with which individuals spoke suggested that these benefits were not only important to them as peers, but that they also provided a source of empowerment to the peers who were working with a CPS.

The benefits identified by peers in the focus groups were consistent with the literature on peer support in mental health. Responses and themes suggest that there is an improvement in self-image, personal well-being, and hope. There may also be an increase in social networks because of the encouragement the CPS provides to decrease isolation and the willingness to "literally open the front door." Some of the benefits found in the literature, however, were not reflected in responses of peers in the focus groups. Specifically, focus group participants did not mention reductions in symptoms or decreased amounts of time in hospitals, though these benefits have been identified in past research (e.g., Chinman et al., 2001; Davidson et al., 1999). The focus group questions were designed to allow the participants to direct the conversation and identify what was most important to them. Although decreased symptoms and length of time in the hospital may be long-term outcomes of peer support, it may not be the most important benefit to the peers in this study. The absence of the theme of symptom improvement may also be a result of the role that CPS has taken within the mental health system. Since CPSs are less focused on a traditional medical approach, they may emphasize recovery and building upon existing strengths of the peer rather than focusing on specific symptoms. The expectations of potential benefits by peers not receiving CPS services are not significantly different from the benefits reported by those who had received CPS services. In other words, people's expectations of CPS services were similar to the benefits reported by those who do receive services.

Expectations are not typically congruent with what a person actually receives across a variety of services within and outside of mental health (Noble, Douglas, & Newman, 2001). According to the expectancy-disconfirmation theory, negative disconfirmation would lead to a lower satisfaction with the service (Oliver, 1980). Much attention is focused on encouraging positive but accurate expectations to encourage use of new products, medications and services with the use of strong disclaimers that "results may vary." Many advertisements for new diet products, for example, include depictions of an individual who has had extraordinary success, only to see "results not typical" in the fine print. Advertisements that suggest positive results encourage positive expectations that will seldom be met by the actual result of the product. It is important to have realistic expectations of a service to avoid false hopes for that service. The results of this study suggest that peers are familiar with CPS services and have realistic expectations of the service. While CPS services in Kansas are a recent addition to the mental health system, they have been widely discussed by peers involved in the consumer movement. This occurs through CROs, mental health centers, and word-of-mouth. The descriptions through these various venues appear to be fairly accurate, leading to accurate expectations of the service. Peers are familiar with the concept and use of peer support, which may have been especially true among peers who were at the Recovery Conference.

Conclusion

It is important to look at the initial perceptions of a service when it is newly introduced. This study intended to provide an initial look into the perceptions of CPS services as understood by peers. As was demonstrated, there seems to be a positive response to CPS among peers in Kansas. The expectations are similar to the perceived benefits when peers begin to receive the service, resulting in a high level of satisfaction. Further, high levels of satisfaction occur in areas identified as most important by peers, which include higher quality of mental health services, hope, social interaction, guidance, and personal enhancement.

There were several limitations to this study. First, the sample was obtained from peers attending the 2009 Kansas Recovery Conference. Attendees at this conference may have been more knowledgeable about recovery and peer support because of their attendance at the conference. Second, since CPS services are such a recent addition to the mental health system, the services provided may differ depending on the demands of the local mental health center. While all CPSs receive a standardized training with a special emphasis on recovery, the actual service may differ depending upon location. The benefits expected and experienced, however, were tied to the unique nature of CPS services based on experiential knowledge and peer support. It is too early to assess outcomes of CPS services but it is important to continue assessing satisfaction with services and whether expectations are being met. This will result in a greater understanding of peer support as a paid position in the mental health system.

This study on expectations of CPS services provides initial findings that peers were going into CPS services with an accurate expectation of the benefits that the service provides. The results demonstrate that peers have congruent expectations about the benefits of CPS services before receiving the service and once they receive the service. Overall, initial perception of CPS services is positive. The encouraging views of CPS suggest that there may be many benefits of strengthening the CPS program in the mental health system. Satisfaction is high, as are the perceived benefits. These results are encouraging as they indicate a powerful beginning to paid peer support in the mental health system.

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