Predictors of Job Satisfaction Among Peer Providers on Professional Treatment Teams in Community-Based Agencies

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Objective: **The purpose of this study was to examine factors that predict job satisfaction among peer providers employed on professional treatment teams in community-based behavioral health agencies.** ***Methods:*** **Surveys via Internet and postal mail gathered data from 100 members of the National Association of Peer Specialists who met study criteria. A multiple regression analysis was conducted to evaluate role clarity, psychological empowerment, supervisory alliance, coworker support, and inclusion and exclusion in organizational processes as predictors of job satisfaction.** ***Results:*** **The regression analysis revealed that of the five predictors, role clarity and psychological empowerment were significant predictors of job satisfaction when analyses controlled for age, level of education, and tenure.** ***Conclusions:*** **The results of this study reveal that peer providers found satisfaction in an integrated work environment that included clearly defined roles, independent functioning, and respect for the expertise that peer providers possess. (*Psychiatric Services* 64:181–184, 2013; doi: 10.1176/appi.ps.001452012)**

Peer-provided services are one of many innovations generated by the consumer recovery movement. Peer providers are individuals with a history of psychiatric disabilities who have received training to provide mental health services in collaboration with mental health professionals. The duties of peer providers vary, but research suggests that these services are associated with positive consumer outcomes, including reduced symptoms, increased functioning in activities of daily living, enhanced sense of empowerment, and decreased service utilization (1,2).

The effectiveness of peer providers has been established, yet barriers thwart their employment on professional treatment teams. These barriers include negative attitudes toward peer providers among nonpeer coworkers, role ambiguity, and lack of supervision and supervisory support (3,4). However, noticeably missing from the literature are the specific benefits to peer providers of their inclusion on professional treatment teams.

Job satisfaction is considered the primary, nonmonetary benefit of employment (5). Predictors of job satisfaction have been identified and are consistent with the removal of barriers to the employment of peer providers on professional treatment teams. Among these predictors are role clarity, strong coworker support, rapport with supervisors, inclusion in critical organizational processes, and psychological empowerment (6,7). The purpose of this study was to examine the significance of these variables as predictors of job satisfaction among peer providers employed on professional treatment teams in community mental health centers.

Methods

The sample for this study was purposively selected from the membership of the National Association of Peer Specialists, an organization that comprises certified peer specialists, potential peer specialists, supportive nonpeer providers, and others who support persons with psychiatric disabilities. Participants were recruited through written explanations about the research printed in the organizational newsletter by both the researcher and the association director. Survey data were gathered during a two-month period from April through June 2010. The surveys included a brief summary of the study and an informed consent statement. Participants' consent was signified by completion of the survey. Procedures for the study were approved by and followed the terms of the university's institutional research protocol.

Surveys were distributed to all 875 members of the organization. Once data gathering was completed, individuals who were not peer specialists or could not be contacted were removed from the sample, leaving a total sample pool of 770. In total, 381 members responded, rendering a response rate of 49%. Of the 381 responses, a total of 100 respondents met inclusion criteria of paid employment as a peer specialist in a community mental health center on a treatment team with nonpeer providers.

Sixty-four percent of the sample were female, and the mean±SD age of participants was 50.32±9.77 years (range 21–68). The racial composition of the sample was 87% white, 8% black, 1% American Indian/Alaskan

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Table 1

Multiple regression results for predicting job satisfaction of 100 peer providers in community mental health centers[a]

Measure	B	SE	β	t	p
Constant	.350	.569		.62	.540
Role clarity	.352	.101	.436	3.50	.001
Coworker support	.031	.119	.027	.26	.794
Supervisory alliance	.059	.076	.076	.78	.440
Inclusion and exclusion	.164	.119	.170	1.38	.171
Psychological empowerment	.303	.141	.216	2.15	.034
Age	.011	.007	.110	1.61	.112
Level of education	.078	.050	.104	1.56	.124
Tenure in position	.001	.002	.028	.38	.706

[a] R^2=.636, adjusted R^2=.602, p<.001 (adjusted for age, level of education, and tenure in current position)

Native, and 4% multiracial. The ethnicity of the sample was 84% non-Hispanic and 4% Hispanic. The educational level of the sample ranged from a high school diploma or GED to a doctoral degree or professional degree; the average educational attainment was an associate's degree. [Additional demographic information is available online in a data supplement to this report.]

Each of the five predictor variables and one outcome variable were measured with instruments that have been well validated in studies of social service, nursing, and education professionals but not with the population in this study. A factor analysis was conducted on each of the measures for the purposes of data reduction and to explore what, if any, changes occurred to the conceptual factor structure of the measures when applied to this population and sample. A threshold of .55 for factor loadings was established for the sample size.

Job satisfaction, the single outcome variable, was measured with the Job Satisfaction Scale developed by Quinn and Staines (8). This three-item measure of overall job satisfaction utilizes a 5-point Likert scale, with responses ranging from strongly disagree to strongly agree. The factor analysis yielded a one-factor solution, with three items loading at .55 or above (Cronbach's α=.895).

Among the five predictor variables, role clarity was measured with the 12-item role ambiguity subscale of the Role Ambiguity Scale (9). The items explore the degree of clarity of duties, authority, allocation of time, and relationships with others; the clarity or existence of guides or directive policies; and the ability to predict sanctions as outcomes of behavior (9). This scale consists of a 7-point Likert scale with responses ranging from very false to very true. The factor analysis yielded a one-factor solution, with ten items loading at .55 or above (Cronbach's α=.937).

Psychological empowerment was measured with the Psychological Empowerment Scale developed by Spreitzer (10). This scale consists of 12 items rated on a 5-point Likert scale, with responses ranging from strongly agree to strongly disagree. This measure has four identified subscales: meaning, competence, self-determination, and impact. However, the factor analysis in this study yielded a one-factor solution with five items total that included items from each of the subscales except the competence subscale (Cronbach's α=.815).

Coworker support was measured with the six-item Peer Support Scale developed by Abbey and colleagues (11). This scale consists of six items rated on a 5-point Likert scale with possible responses ranging from not at all to a great deal. The factor analysis yielded a solution in which all items loaded above the threshold (Cronbach's α=.922).

The Supervisory Working Alliance Inventory developed by Effstation and colleagues (12) was used to measure the supervisory working alliance as a predictor of job satisfaction. The instrument was developed to evaluate the quality of the relationship between supervisors and providers in clinical mental health settings by using a 7-point Likert scale with responses ranging from almost never to almost always. The 12-item subscale measuring supervisor's rapport with employees was used in the study. The factor analysis yielded a one-factor solution with 11 items loading at .55 or above (Cronbach's α=.933).

The final predictor variable, inclusion and exclusion in key organizational processes, was measured with the Inclusion/Exclusion Scale developed by Mor-Barak and Cherin (13). This instrument consists of 14 items rated with a 6-point Likert scale on which responses range from strongly disagree to strongly agree, with higher scores reflecting higher levels of inclusion. The scale is structured in three subscales—work group involvement, influence in decision making, and access to communications and resources. The factor analysis in this study yielded a one-factor solution consisting of nine items, including items from the work-group involvement and influence in decision-making subscales. However, none of the items from the access to resources subscale loaded at an adequate level in the final factor model (Cronbach's α=.827).

The individual predictors of job satisfaction were analyzed by multiple regression.

Results

Multiple regression analysis was conducted to determine the significant predictors of job satisfaction. The results revealed that only two variables, role clarity and psychological empowerment, significantly predicted job satisfaction among peer providers employed on professional treatment teams in community mental health centers when analyses controlled for age, level of education, and tenure in current position (Table 1). Role clarity (β=.436) was highly significant (p<.001), and psychological empowerment (β=.216) was significant (p<.05). The adjusted R^2 for this model was .602.

Inclusion and exclusion in key organizational processes, coworker support, and supervisory alliance were not significant predictors of job satisfaction in the study sample.

Discussion

Role clarity was a significant predictor of job satisfaction among peer providers, which demonstrates that, like employees in other studies, peer providers experienced job satisfaction as a benefit of role clarity. However, peer providers benefited from role clarity in unique ways because of the complexity of their role and identity in the organization.

Peer providers are unique in that the role of peer provider represents a significant role transition from consumer to provider, typically within the same organization. However, by definition, identification as an individual with a psychiatric disability is sustained in the role of peer provider. The ability of the organization to define clear duties and expectations for the peer provider as well as support his or her role as a treatment team member creates a new identity for an individual with a psychiatric disability. The role of an individual with a psychiatric disability within the organization is not inevitably one of dependence and limitation but is clearly defined as one of rank and responsibility. With the role transition facilitated by this clarity of roles, the peer provider is able to negotiate his or her identity as an individual with a psychiatric disability who is also a member of the treatment team.

Psychological empowerment was the second significant predictor of job satisfaction among peer providers in this study. Psychological empowerment is a model of motivation in the workplace and operationalizes how peer providers can benefit from providing peer support services as employees rather than as clients who achieve some clinical measure of empowerment, such as increased self-esteem.

The exploratory factor analysis revealed a factor structure that was notably different from the original measure. These differences may be due to how the instrument was administered. Other possible explanations are that the items measure different concepts when used with this population or that the concept remains the same but is perceived differently by the study population. The unique qualities of the peer provider population and its relationship to professional treatment teams in community mental health centers seem to indicate that differences in how impact, meaning, self-determination, and competence are perceived by peer providers were at the root of the changes in the factor structure in this study.

The final factor model for psychological empowerment included items representing impact, meaning, and self-determination. No items from the competency subscale were included. The items in the final factor structure reflected the importance to the peer provider of having an impact on the work environment, having independence in organizing and performing duties, and performing meaningful work. The creation of one factor from these items suggests that peer providers are motivated and inspired by a sense of power within the organization, both over the work environment and themselves.

The exclusion of competence as a concept in the final model was interesting. Competence was defined in the study as the degree to which a peer provider believed that he or she could perform tasks skillfully (14). The three competence items in the psychological empowerment measure had high scores, but these items were not conceptually associated with a sense of power within the organization. One interpretation of this finding is that peer providers can experience a strong sense of competence in performing their duties and still not feel that competence positively affects their power in the organization. This could be due to a difference in how competence is defined by peer providers in that the nature of their relationship with the consumer differs from that of nonpeer providers. According to Mead and colleagues (15), providing effective peer-provided services requires the peer to demonstrate a depth of understanding of and partnership with the consumer that is not necessarily sought by nonpeer providers nor considered a criterion for competent practice.

The variables in this study suggest that peer providers are most satisfied with their jobs on treatment teams in community mental health centers when their role and duties are well defined and lead to the experience of having authority in the work environment and independence in performing their duties. The relationships that they have with their nonpeer coworkers and supervisors are valued for their contribution to this authority and independence.

There are two significant limitations to this study, the first being the small sample size. Despite the support of the National Association of Peer Specialists, the goal of accessing a large pool of peer providers who would meet the very specific inclusion criteria for the study proved unrealistic. However, the impact of the small sample size was remedied somewhat by establishing appropriate significance thresholds in the exploratory factor analysis and by reducing the data with summated scales.

The generalizability of the findings of this study are limited because of the small sample size, recruitment strategy, lack of randomization, and modifications made to the measures on the basis of the factor analysis. However, this lack of representativeness is presumed, because there are no available data that provide a profile of peer providers in general or those employed on treatment teams in community mental health centers.

Conclusions

This study sought to identify how peer providers of mental health services can achieve job satisfaction as an occupational benefit of inclusion on treatment teams in community mental health centers. The findings from this study provide useful information regarding how specific individuals with psychiatric disabilities wish to relate to their environment and to those with whom they are associated. Not unlike most employees, peer providers in this study valued an environment supportive of their independence and respectful of the wisdom and expertise that they possess. The difference between most employees and peer providers, however, is what counts here. Peer providers offer a unique and specialized service outside of any mental health training. The educational know-how combined with the experiential understanding of psychiatric disability yields a new dimension in mental health support services. The

consequences of bringing this unique combination of knowledge and experience to bear on one's mental health trajectory are part of the new frontier in mental health research.

Acknowledgments and disclosures

The author reports no competing interests.

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