UNDERSTANDING PEER SUPPORT WORK ROLE IMPLEMENTATION, WORK-LIFE BOUNDARY NAVIGATION AND TECHNOLOGICAL BOUNDARY TRANSCENDENCE IN A VIRTUAL SPACE

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Preface

This dissertation is an original scholarly work of Elmira Mirbahaeddin. The fieldwork reported in chapters 3 and 4 involved human participants and was granted ethical approval by the Research Ethics Board (REB) of the University of Ottawa (Reference number S-11-20-6226).

A version of Chapter 2 has been published in the journal Administration and Policy in Mental Health and Mental Health Services Research [Mirbahaeddin, E., & Chreim, S. (2022). A Narrative Review of Factors Influencing Peer Support Role Implementation in Mental Health Systems: Implications for Research, Policy and Practice. *Administration and policy in mental health*, *49*(4), 596–612. https://doi.org/10.1007/s10488-021-01186-8]. I was the first author and responsible for searching the literature, organizing, and analyzing selected articles, as well as quality assessment and manuscript composition. Professor Samia Chreim provided guidance to conception and design, and thoroughly reviewed until finalized.

Chapters 3 and 4 were motivated by the unprecedented COVID-19 pandemic, during which peer support became highly needed and significant. These chapters were based on a Partnership Engage Grant, COVID-19 Special Initiative, funded by the Social Sciences and Humanities Research Council (Grant # 1008-2020-1020). I worked under the supervision of Professor Samia Chreim as the PI, and received mentorship on establishing and nurturing partnership with a community organization, as well as on all aspects of the research including ethics application, design, data collection, analysis, report writing and dissemination.

A version of Chapter 3 has been published in *BMC Public Health* [Mirbahaeddin, E., & Chreim, S. (2023). Work-life boundary management of peer support workers when engaging in virtual mental health support during the COVID-19 pandemic: a qualitative case study. *BMC Public*

Health, 23(1), 1-15. https://doi.org/10.1186/s12889-023-16488-9]. A version of Chapter 4 has been submitted to a scholarly journal and is under peer review. For both manuscripts, I was the principal researcher and responsible for all major areas of research design, data collection and analysis, as well as manuscript composition. Professor Samia Chreim provided ongoing support for partnership with the community organization and guidance on design, data collection, data analysis and manuscript edits.

Thesis Abstract

As mental health care increasingly embraces recovery principles, the role of peer support workers (PSWs) has gained recognition. The work that mental health PSWs do became particularly important during the COVID-19 pandemic, when increased needs for mental health care became apparent but were often unmet. This article-based doctoral thesis adopts an interdisciplinary perspective that combines research on management and organization with research on health care and systems. The thesis examines the mental health peer support role and its integration within teams, organizations, and health systems. It also considers the peer support role as it was enacted in a virtual space, which became a requirement due to pandemic work-from-home mandates. Within the context of the virtual space, PSWs confronted work-life boundaries that they had to navigate as they enacted their work roles. The virtual space also presented technological and social challenges to and opportunities for peer support, which are examined in this thesis from the points of views of PSWs and peers. Overall, this thesis attends to the PSW role more generally, and to peer support work in the specific context of a virtual environment. The thesis is composed of three studies, the second and third of which had to be adapted to the unexpected challenges and opportunities posed by the COVID-19 pandemic.

Study 1 (presented in Chapter 2) is a narrative review that synthesizes the literature on factors influencing formal PSW role implementation in mental health systems. The findings are synthesized in a multilevel framework consisting of macro, meso and micro level influences. The analysis reveals that macro-level influences on PSW role implementation include socio-cultural, regulatory, political and economic factors, most of which act as obstacles. At the meso level, organizational culture, leadership, and human resource management policies play a significant role. Micro-level influences center around PSWs' relationships with team members. Interlevel

interactions are also discussed. This study is co-authored with Professor Samia Chreim and was published in *Administration and Policy in Mental Health and Mental Health Services* in February 2022.

For Studies 2 and 3, qualitative data were collected from members of a peer support organization situated in Ottawa. This organization is a publicly funded, not-for-profit organization that provides services free of charge to people experiencing mental health and addictions challenges. Due to the pandemic, all services and operations of this organization transitioned to remote services involving virtual platforms.

Study 2 (presented in Chapter 3) is a qualitative case study that delves into the work-life boundary challenges and management of PSWs who were providing virtual mental health support during the pandemic. The study identifies temporal, physical, and task-related boundary challenges in work-life domains. Strategies employed by PSWs to manage these boundaries include segmenting and integrating work and personal domains. The study highlights the importance of self-care and the need for training on work-life boundary management for mental health workers. This research is co-authored with Professor Samia Chreim and is published in *BMC Public Health*.

Study 3 (presented in Chapter 4) focuses on the transition from in-person to virtual mental health peer support services. Through semi-structured interviews with PSWs and service users (or peers), the research examines how technological factors act as bridges and boundaries to mental health peer support services, and whether and how a sense of community can be built or maintained among PSWs and peers in a virtual space when connections are mediated by technology. The findings highlight the mental health peer support needs that were (un)met

through virtual services, the technology-based boundaries that were manifested and the steps taken to remove some of these boundaries, and the strategies employed by the organization and its members to establish and maintain a sense of community in a virtual environment marked by physical distancing and technology-mediated interrelations. The manuscript pertaining to this study is co-authored with Professor Samia Chreim and will be submitted soon to an academic journal.

Overall, this thesis presents a unique and multi-faceted exploration of the implementation of peer support worker roles in mental health systems and their adaptation to virtual environments. It makes a number of contributions. The multilevel framework developed in Study 1 not only advances knowledge in the field but also offers a structured approach for policymakers and organizations to enhance the formal incorporation of PSW roles into mental health systems. Study 2 provides valuable insights into the nature of work-life boundaries in a virtual space, an important topic at a time when peer support workers and organizations are considering whether and how to maintain some form of virtual work post-pandemic. Study 3 adds to knowledge by highlighting the significance of virtual peer support beyond pandemic conditions. It also enhances understanding of the need for technological adaptation in mental health services and for community building regardless of the model of service. Limitations and implications for research, practice and policy are addressed.

Acknowledgements

I am deeply grateful as I stand at the conclusion of my doctoral journey. I take this moment to express my appreciation to the ones that have played pivotal roles in shaping this endeavor.

First and foremost, I extend my gratitude to my supervisor, Dr. Samia Chreim. Her solid guidance, unique expertise, and constant backup have been the cornerstone of my academic growth in my PhD journey. Through her mentorship, I have enhanced my research skills and developed my overall skillsets as a scholar prepared for the next phase of my professional life. We experienced an unprecedented global pandemic that could jeopardize my PhD, however, with Dr. Chreim's support and dedication to supporting my thesis work, I could maintain my thesis work with strength and resilience.

I am grateful to the Telfer School of Management at the University of Ottawa for offering me the privilege of pursuing my doctoral studies. The support provided by the school, spanning from academic resources for research and beyond has been instrumental. A special mention is reserved for the members of my thesis committee, whose insights and constructive feedback have steered my research in the right direction. My gratitude extends to the faculty members of the PhD program in Management whose support enriched my academic experience. Additionally, I recognize the administrative staff whose assistance and guidance have been vital, particularly in moments of uncertainty during the COVID-19 pandemic.

I am greatly thankful to the community organization that cooperated with me on the empirical phase of the thesis research. Their partnership not only enriched the empirical foundation of my thesis but also reaffirmed the real-world relevance of my academic pursuits.

Turning to the personal sphere, I am infinitely grateful to my favourite person in the world, my loving husband and best friend, Peyman Varshoei. From the very beginning, Peyman has been more than a companion in my PhD journey – he has been my confidant, my encourager, and my faithful supporter. We first met on the orientation day of the newly admitted PhD students at Telfer School without knowing that we will become life partners and peers in the PhD program! Peyman has patiently and wholeheartedly listened to my spoken and non-spoken words. He filled my days during the program a fantastic personal experience filled with fun and exceptional memories. In addition, I must thank my friends whose camaraderie and kindness provided me with the strength to overcome challenges accompanied by immigration to Canada independently, and later, navigating through the solitude imposed by the COVID-19 pandemic.

Above all, my family, Maman Pooran, Baba Siama, and Dr. Khashayar hold an irreplaceable place in my heart, they are my *Raison d'êtres*. They gave me the strength to be resilient during doctoral training. With every achievement, they celebrated; with every setback, they empathized. I am forever grateful to my family who gave me the ground to jump as high as I could.

Finally, I would like to extend my appreciation for all the financial support that I received throughout the doctoral studies. I would like to thank the Telfer School Management for providing a funding package, conference travel grants and teaching opportunities. I am truly grateful to Dr. Ivy Bourgeault whose financial support was invaluable through research assistantships in the early years of my PhD. Also, to Dr. Samia Chreim for providing me with research assistantships in addition to the opportunity to collaborate with her on a grant project (Partnership Engage Grant COVID-19 Special Initiative, 2020). I am honored to have been a recipient of scholarships and awards including the Queen Elizabeth II Scholarship in Science and Technology (QEII-GSST-2020), the University of Ottawa Excellence Scholarship (2020),

Association of Professors of the University of Ottawa Award (2018), and Duncan and Deb Cross Award (2022).

In closing, this thesis stands as a testament not just to my academic journey but to the combined efforts of those who have guided, supported, and believed in me. To all those mentioned here and to those whose contributions may be unspoken yet deeply felt, I offer my sincere and enduring gratitude.

With heartfelt thanks,

Elmira Mirbahaeddin

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CHAPTER 1

THESIS INTRODUCTION

Peer support in mental health services refers to the provision of intentional support, empathy, and understanding by individuals who have had lived experience of mental health challenges to others facing similar challenges (Mulvale et al., 2019). Individuals who provide peer support and are employed by organizations are often referred to as "peer support workers" (PSWs). Peer support is based on the belief that individuals who have navigated their own recovery experiences hold unique insights and lived practical knowledge that can be helpful in supporting others in their recovery (Mead, Hilton & Curtis, 2001). Peer support has been categorized into four groups ranging from voluntary to formal, specifically: self-help groups, peer-run services, peer partnerships, and peer employees (Solomon, 2004). This thesis focuses on peer employees or paid PSWs, who—unlike those who engage in voluntary peer support—hold formal roles in mental health/social services organizations.

The World Health Organization (WHO) has recognized the role of peer support in community-based and recovery-oriented mental health services—through the Quality Rights initiative that provides the necessary tools and skills to develop sustainable mental health services across nations (World Health Organization, 2017). The notion of recovery in mental health refers to a multidimensional process that involves individuals actively engaging in their own well-being, making self-determined choices, fostering social connections, and pursuing a meaningful life despite the presence of mental health challenges (Mead, Hilton & Curtis, 2001). Despite the growing attention to the incorporation of recovery-oriented services in mainstream mental health care, this goal has not been easily achievable given the complexities associated

with effective adoption of these services in mental health, e.g., resistance to change, policy alignment and resource allocation. The Mental Health Commission of Canada has suggested that the realization of a recovery-oriented mental health system requires "ongoing system change and training for professionals to develop the skills to work in and deliver recovery-oriented, anti-oppressive services in partnership with peer providers" (Cyr et al., 2016, p. 6).

Historically, peer support found strong expression during the mental health consumer movement in the 1970s. Peers with lived experiences of mental illness advocated for the experiential knowledge and support that they could provide in the treatment and care of mentally ill people (Davidson et al., 2012). However, this movement had been challenged because of the prevailing medical model in mental health systems (Solomon, 2004). Medical professionals have dominated service provision by maintaining boundaries that have restricted the involvement of new occupations in the formal provision of care (Freidson, 2001). These elites have protected their professional positions by underlining their esoteric knowledge gained through academic qualifications and credentials (Freidson, 2001). Other means of closure to new caring occupations have included licensure requirements and resource monopolization (Abbott & Meerabeau, 1998). However, as the benefits of peer support became increasingly recognized in the 1990s, mental health organizations and jurisdictions began integrating PSWs into their programs and services. Currently, in mental health systems, the implementation of PSW roles in paid and formal positions still faces challenges and is subject to various influencing factors (Ibrahim et al., 2020). These challenges have been addressed in various studies, most of which tend to focus on a limited set of implementation issues. The fragmentation in the literature was a major motivation for the first study in this thesis.

The thesis had been originally conceived to include empirical work on the implementation of the PSW role in various types of settings (community mental health and inpatient settings), but the advent of the COVID-19 pandemic created extensive pressures for health services and support organizations and led to lockdowns, removing my ability to access the sites for the study. The pandemic also created new research avenues in relation to virtual peer support, the importance of which was acknowledged by the WHO, which in a report, highlighted how virtual peer support groups had scaled-up community-based mental health services in several countries (World Health Organization, 2021). The adaptability of peer support programs in transitioning to virtual services when limitations increased on access to in-person services has been emphasized (Merchant et al., 2020). Given the pandemic and my inability to access sites for the study of PSW role implementation, I pivoted and, in the later parts of my thesis work, focused instead on peer support and PSW roles in the context of virtual services. This meant that seamless linkages and transitions across the three Essays in the thesis could not be maintained. Nevertheless, all three Essays are underpinned by a common theme.

The overarching problematique that underlies this thesis involves PSWs' role challenges, which is a common theme across the three Essays presented in this thesis. This is an important topic because PSWs can play a significant role in mental health systems, as mentioned earlier, yet their services remain under-utilized and under-appreciated. Focusing on the challenges and opportunities associated with implementation and enactment of PSWs' role brings the subject to light and contributes to an important conversation on recovery approaches in mental health services. In the first Essay, the multi-level challenges at the system, organization, group and individual levels that influence PSW role implementation are mapped. In the second Essay, considering that the COVID-19 pandemic and mandatory lockdowns imposed new work

circumstances on PSWs, requiring them to work from home, I focused on the challenges of managing work-home boundaries as the PSWs enacted their work roles from home. In the third Essay, I continued with the role challenges associated with virtual work, and focused on difficulties associated with remote peer support involving the use of technology. The third Essay also provides an understanding of how service users experienced virtual peer support services when PSW's roles were mediated by technology - a novel topic that needed to be explored to gain a more developed understanding of virtual peer support services. All three Essays focus on role challenges, but also address the opportunities associated with role implementation, with Essays 2 and 3 focusing on the virtual role.

Virtual work enabled PSWs to effectively maintain their networks with peer communities, even in jurisdictions that declared lockdowns (Cheng et al., 2020; Moreno et al., 2020). Peer support organizations quickly adapted to virtual work in order to remain available for their service users. This unexpected transition brought new challenges for these organizations and their employees. PSWs found themselves in the position of having to perform their work role and provide services from their homes. This created work-life boundary challenges that are the subject of the second paper.

Virtual work requires the utilization of diverse technologies (Witteveen, 2022) that can create a set of challenges and opportunities in enacting the PSW role and in relation to accessing services. For example, limited technology literacy can create boundaries to the provision and utilization of virtual mental health support, but technology offers the opportunity to provide mental health support services remotely. For individuals providing and individuals seeking mental health peer support, participating in virtual support groups may result in a diminished sense of community compared to in-person sessions. However, in a context of lockdowns, being

connected to other service providers and users helps to reduce isolation and to create a sense of togetherness. These technology-based challenges and opportunities for the PSW role and for service users are addressed in the third paper.

The uniqueness of the thesis lies in its focus on a distinct topic: PSWs and their roles within the Canadian context, a workforce often overlooked in both literature and policy discussions. Another distinctive aspect is the examination of the PSW role within the virtual service setting. This analysis brings a fresh perspective, particularly considering the intersection of peer support and technological advancements, providing valuable insights as mental health care undergoes changes in a post-pandemic era.

The remainder of this thesis is organized as follows. In the rest of this chapter, I will provide a brief review of the theoretical and methodological approaches that are applied in the subsequent chapters. Additionally, I will present a description of the case upon which the two empirical chapters are based. The forthcoming chapters of this thesis collectively delve into an exploration of the subject matter. In Chapter 2, a review paper sets the stage by synthesizing the existing literature and establishing a foundation for the discussion on PSWs' role implementation in mental health systems and organizations. Chapters 3 and 4 transition into empirical Essays, where findings and insights collected from empirical research during the COVID-19 pandemic shed light on different aspects of virtual peer support work role and peer support services. Moving forward, Chapter 5 ties together the threads, showing how the review and the Essays fit into a bigger picture. Overall, these chapters contribute to our understanding of peer support and its implications.

Theoretical Approach

This thesis adopts an interdisciplinary approach that combines theoretical insights and research on organization and management and on the health care system. Specifically, the focus has been on research and concepts pertaining to challenges and opportunities of role implementation and virtual service provision of peer support in the mental health system. A multilevel approach informed the review and analysis of factors influencing the PSW role implementation in mental health systems. The onset of the COVID-19 pandemic necessitated a shift in the direction of the thesis, impacting the second and third Essays. The focus of these Essays turned to understanding dynamics of virtual peer support work and services, and integrated the notions of boundary theory in work-life interface, and the sense of community.

Multilevel perspective: PSWs role challenges in mental health systems and organizations

Multilevel frameworks have enabled a better understanding of factors that influence the implementation of changes in roles, practices and groups in health systems (Chreim et al., 2007; Kooij et al., 2018; Nelson et al., 2014; Smith et al., 2019). Multilevel frameworks view organizational phenomena as unfolding within a complex broader environment and consider it essential to understand nested arrangements (Hitt et al., 2007). A multilevel perspective also helps shed light on cross-level interactions (i.e. how factors at one level interact with factors at another level). Interlevel analyses allow researchers to build theoretical and empirical bridges across levels and provide a strong understanding of practical problems (Hitt et al., 2007). A multilevel framework prompts attention to factors operating at different levels and their interactions.

There is extensive research showing the importance of peer support for mental health recovery (Cyr et al., 2016; McCarthy et al., 2019; Otte et al., 2020b) and advocating for the inclusion of peer support services as an integral part of mental health systems and organizations (Gillard et al., 2015; Mulvale et al., 2019; World Health Organization, 2022). Research shows that despite its benefits to mental health, peer support is not well integrated within mainstream mental health services (Rebeiro Gruhl et al., 2016). There are also several studies that address various factors –mostly obstacles – that influence formal implementation of the PSW role in mental health systems or organizations, however, there is a lack of a comprehensive framework that synthesizes the factors and addresses their interlevel interactions. Some authors have described the current evidence as "frustratingly messy" (Gillard, 2019, p. 343). In an attempt to organize a highly fragmented body of research, I adopted a multilevel framework to synthesize the factors that influence PSW role implementation.

I adapted and integrated insights from various multilevel frameworks in the extant literature, taking from these frameworks the elements that were pertinent for an understanding of role implementation. One such framework is the Consolidated Framework for Implementation Research (CFIR) by Damschroder et al., (2009) which offers various levels of investigation including outer setting (e.g., policy), inner setting (e.g., resources in an organization), process (e.g., engagement of stakeholders), and individual health professionals (e.g., individuals' knowledge). Another model is the Fit between Individuals, Tasks, and Technology (FITT) framework that highlights, among others, the following levels: individual professional, social context, organizational context, and economic and political context (Grol & Wensing, 2004). A third model offered by Chreim et al. (2007) was highly pertinent because it was applied to track role reconstruction and implementation in health care by focusing on forces at institutional,

organizational and individual levels, and their interactions. Based on these frameworks, I proposed a model in Essay 1 to synthesize the literature on PSW role implementation that includes macro level systems and broader structures that act as sources of role legitimacy for PSWs, but also hinder role integration through professional power dynamics. At the meso level, there are various organizational factors (e.g. organizational culture and human resources policies) that influence role implementation. Last, but not least is the micro level of interactions (e.g. among PSWs and other organizational members) that also influence PSW role implementation.

Virtual work and service

Virtual work is a growing phenomenon that has gained traction with the advancement of telecommunication technologies and that became particularly prevalent during the COVID-19 pandemic. *Virtual work* is defined as "any work interaction with others that is not conducted in person (face-to-face) and that uses technology tools to transfer thoughts or ideas" (Makarius & Larson, 2017, p. 160). Prior research into virtual work predominantly revolves around virtual teams, frequently overlooking the individual participants who are viewed as passive contributors (Makarius & Larson, 2017). In this thesis, I examine virtual work at the individual level, and consider the sudden move to virtual work due to pandemic lockdowns. I also consider services delivered and received virtually. In Essays 2 and 3, PSWs' adjustment to virtual work from home, and the technologically mediated interactions between PSWs and peers are respectively the focus of attention.

PSWs found themselves in situations where they needed to acquire new skills and adopt strategies to maintain the quality of support despite the absence of in-person interactions (Fortuna, Solomon, & Rivera, 2022). The transition to virtual services involves not only digital proficiency but also accessibility (Athanasiadou & Theriou, 2021; Litchfield, Shukla, Greenfield,

2021). In addition, the utilization of only virtual platforms for human interactions can impact the sense of community (Stewart & Townley, 2020) which is characteristic of peer support. Essay 2 addresses how PSWs navigated work-life boundaries when prompted to work from home using virtual platforms. Essay 3 gives voice both to the PSWs and peers by exploring and conceptualizing how technological factors can act as bridges and boundaries to mental health peer support services and community.

Boundary theory in work-life interface

Theories of boundaries, role transitions and boundary management (Ashforth, Kreiner, Fugate, 2000; Bacharach, Bamberger & McKinney, 2000; Kreiner, Hollensbe & Sheep, 2009; Kossek & Lautsch, 2012) informed this thesis and were pertinent to an understanding of the boundaries that became salient for PSWs whose work transitioned to their personal living space. The term "*boundaries*" has been commonly used to delineate demarcations between work and non-work involving one's home or personal life (Allen et al., 2014; Ashforth et al., 2000; Rothbard & Ollier-Malaterre, 2015). These boundaries are conceptualized as social constructions that simplify and categorize surroundings; boundaries help define the extent and limits of a specific domain (Ashforth et al., 2000). Work-life boundaries are fuzzy for individuals working remotely from home. Overlapping domains of work and life can cause strain and/or conflicts between one's professional responsibilities and personal life (Rothbard & Ollier-Malaterre, 2016). Individuals may adopt strategies to achieve a sense of balance when encountering work-life strain. Navigating between work and home roles requires boundary management (Kreiner et al., 2009).

Boundary management tactics can take various forms. Individuals may integrate or segregate the temporal, physical, behavioral or communicative domains (Kreiner et al., 2009).

Some individuals allow permeability between domains, whereas other individuals may segment and avoid spillovers between domains (Allen et al., 2014). Researchers have referred to the "unique" approaches that individuals employ when managing boundaries depending on their preferences and context (Ashforth et al., 2000; Kreiner et al., 2009; Rothbard & Ollier-Malaterre, 2016). Essay 2 uncovers the ways by which PSWs enacted boundary management when engaging in virtual work from home during the pandemic.

Sense of community in virtual space

The concept of a sense of community is particularly relevant to the peer support context because peer support communities are driven by principles that are mainly relational, including the recognition of people's lived experience of a mental health challenge, mutual respect and trust to share and receive experiences in confidence, and non-judgemental attitudes regarding the unique recovery journey of individuals (Mead, Hilton & Curtis, 2001; Cyr et al., 2016). While technology-mediated services were practiced in various mental health settings prior to the pandemic, including peer support (Fortuna et al., 2019 and 2020), the pandemic created a unique circumstance in which telecommunications became the major means through which individuals could interact.

A sense of community is defined as a sentiment of belonging that members experience, a recognition that members hold significance for each other and for the group, and a collective confidence that members' requirements will be addressed through their commitment to staying united (McMillan and Chavis, 1986). In this definition, a sense of community is conceptualized from a relational perspective considering four aspects of membership, influence of members, fulfillment of needs through membership, and shared emotional connection. This conceptualization differs from those that emphasize the importance of the spatial dimension and

that view community as groups of people associated with a physical setting such as a neighbourhood (Nistor et al., 2015). In Essay 3, I examine whether and how the sense of community could be established in a context of physical distancing where interactions and communications are mediated by technological tools.

Methodological Approach

Overall epistemological approach

In both the narrative review and the empirical articles in this thesis, I adopt an interpretive epistemological approach. In the review paper, I conducted an interpretive synthesis of the literature (Greenhalgh et al., 2018) that requires the identification of factors which influence role integration, but that goes beyond identification to subsuming concepts into a more abstract or higher-order structure (Dixon-Woods et al., 2005), while also allowing reflexive description and critique of the findings from extant literature.

In the empirical articles, I also adopted an interpretive approach within an exploratory qualitative investigation. Hennink et al. (2011) described it as a distinctive characteristic of qualitative research that "allows you to identify issues from the perspective of your study participants and understand the meanings and interpretations that they give to behaviour, events or objects" (p.9). By adopting an interpretive approach, I could engage with the participants' unique viewpoints, fostering a comprehensive understanding of their experiences.

The qualitative approach empowered my analysis by allowing consideration of the context and exploration of the novel experiences, perspectives and interpretations of the participants. The qualitative approach allows the conduct of the research within the participants' natural settings (via zoom calls and at their homes). It provides an opportunity to explore how the broader

context shapes participant responses and interpretations (Hennink et al., 2011). The semi-structured interview method allowed me to uncover the subjective viewpoints of the participants with valuable insights into the individual circumstances and factors that shaped their beliefs and reported actions (Marshall & Rossman, Blanco, 2022).

The case: A mental health support organization (MHSO)

MHSO (name disguised to maintain anonymity) is the case study that is the subject of the empirical work.

Background: MHSO is a non-profit grassroots organization founded in the 1990s by a small number of consumers/survivors of the mental health system. It is run by and for people who have lived experience of using the mental health system and has been a community for mutual support and advocacy. The values that drive the organization's vision involve fostering hope, being peer driven, and promoting self-determination, respect and integrity. Building on peers' lived experiences is central in the design and delivery of services. MHSO values the right of a person to make their own life decisions and determine their own destiny. Peers are respected by valuing the diversity of their lived experiences and unique contributions. While the organization remains membership-run, it has formalized its approach to also provide peer support in hospitals, and it collaborates with various community partners to provide recovery education.

Services: MHSO provides mental health and social support services for a mental health and addictions population. These services include peer and family peer support, public education, volunteer opportunities, connecting to other community services. Overall, the goal of these services is to promote hope, recovery and wellness and create a sense of community. The services are free, and a referral is not required. The programs offered by MHSO range from more

targeted peer support groups for specific mental health challenges to those that are more general. In addition, a wide range of recreational programs are offered to foster social connections, for example, through art and crafting, and game trivia night. The PSWs engage in a variety of peer support services offered at MHSO and outside its premises, such as hospitals. Training is another type of service that MHSO provides. It trains users of the mental health system to provide recovery education to other service users. Some of these trained individuals would join the organization through paid employment as PSWs or other roles such as administrative roles.

Impact of COVID-19 pandemic: When pandemic lockdowns were mandated in Ontario in March 2020, MHSO transitioned all its programs and services to virtual platforms. They used online video conferencing tools, mainly Zoom. In addition, they started a new service that was a phone line for 24/7 calls. This phone line was provided since not all service users were able to use technology or access internet connection. The organization was able to offer immediate and significant help to service users without being encumbered by restrictions and wait times that overwhelmed the social and health care system in the early months of the pandemic. The virtual services continued throughout the pandemic.

Data collection and analysis

Participants in this study consisted of members of MHSO. The participants were MHSO managers, PSWs and service users (or peers) with whom I conducted semi-structured interviews. MHSO agreed to post the invitation call for participation in the research through its newsletter. Any interested participants were asked to contact the researcher directly. MHSO was not informed about who did or did not contact the researcher. Individual meetings were scheduled to conduct the interviews via Zoom video calls (or occasionally through phone calls) at a time that was convenient to participants.

For Essays 2 and 3, a total of 13 PSWs, including some who held managerial positions, participated in the interviews. This constituted 62% of the total organizational employees, most of whom held full-time positions. Additionally, 27 peers were interviewed to provide a comprehensive understanding of the experiences of service users. Every individual who expressed interest in participating was interviewed. Participants were given $25 cash gift for participating in the study. One interview was conducted with each of the 40 participants. It should be noted that data gathered from the 13 PSWs was used for both Essays 2 and 3. The interviews with the PSWs covered a wide range of topics and very rich data was gathered, partly through probing. It is essential to emphasize that the topics addressed in Essay 2 differ from those addressed in Essay 3.

Separate semi-structured interview protocols were developed for each of the participant groups (PSWs, managers and service users). These interview protocols are provided at the end of this thesis within the Appendices. The interview protocols included common questions on participants' background, experiences with virtual peer support during the pandemic and beyond, and their views on sense of community. Please see appendices for specific questions to each of the participant groups. Extensive probing based on participants' answers was used.

The overarching analytical approach for this thesis involves thematic analysis (Braun & Clarke, 2006; Major & Savin-Baden, 2010; Miles et al., 2020), and interpretive synthesis informed by Dixon-Woods et al. (2005), Popay et al. (2006) and Briner & Denyer, (2012). Thematic analysis served as the primary method for identifying and organizing recurring themes within the data, which were then situated within the context of the existing literature.

Ethics and confidentiality

Several strategies were used at different stages of this research in adherence to ethical research principles. The study's procedures were thoroughly reviewed by the Research Ethics Board (REB) of the University of Ottawa (crt# S-11-20-6226). During the recruitment, the participants were asked to only contact me to express their interest, and not to inform their managers or colleagues about their participation. I informed the participants that they could book their interview outside of their work hours if they so desired. Separate consent forms were developed for each of the participant groups and their voluntary agreement was obtained before the interviews started. Participants were allowed to ask questions and I informed them of their right to withdraw at any time, and that they would keep the cash gift even if they withdrew.

Transcribed data was anonymized. I ensured that identifying information was disguised and that quotes reported in the papers did not allow identification of the participants. This was also checked with another reviewer (my supervisor) to ensure anonymity of the participant data. An additional measure to protect the identity of the interviewees is described under *Member checking* below.

Member checking

Following the completion of data analysis, the results were shared with the managers and a representative group of PSWs to discuss their comments on the results before sharing them with the other participants. I asked if the analysis and interpretations of the data resonated with their views. Moreover, the logistics of seeking feedback from the staff and service users were discussed. Essay 2 was sent to all MHSO employees. Essay 3 was sent to all 40 participants. Each Essay was sent in an email with recipients in bcc. The email requested feedback on the findings and informed participants that they could ask to have their quotations removed or

modified if they so desired. No one requested removal or edit of quotations. The feedback received from participants on Essays 2 and 3 were incorporated in the respective texts as highlighted in their methods section.

Reflexivity in this qualitative research

Reflexivity in qualitative research is a critical aspect that highlights the self-awareness of a researcher in terms of the biases, subjective judgments and the personal influences that they might have on the research process. Reflexivity is defined as "*a set of continuous, collaborative, and multifaceted practices through which researchers self-consciously critique, appraise, and evaluate how their subjectivity and context influence the research processes*" (Olmos-Vega et al, 2022, p. 2). In the current thesis, I made an ongoing effort to be cognizant about reflexivity implications and the following steps suggested by Dodgson (2019) were taken to address it: demonstrating transparency, clarifying limitations and describing the research setting/context.

I demonstrate transparency in reporting the methods and clarifying the limitations of the research. In each Essay, the process of data collection and analysis are described in detail. I provide thick description of the context involving the who, what, where, and how of the case study setting to inform the reader about the research context. I provide extensive quotations on the themes reported in each of the Essays to offer the reader an opportunity to agree or disagree with my analysis. Importantly, another researcher (my supervisor) was involved in reviewing my analysis on the basis of the data, and when our interpretations differed, I returned to the pertinent data to find answers. This process offered confidence that my analysis was not based on my subjective experiences, but was well anchored in the data from participants.

Next, I present the three Essays that constitute the central components of the thesis.

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CHAPTER 2

ESSAY 1: A Narrative Review of Factors Influencing Peer Support Role Implementation in Mental Health Systems: Implications for Research, Policy and Practice

ABSTRACT

With increasing calls to incorporate recovery principles into conventional mental health care, the importance of peer support worker (PSW) services has gained attention. However, studies consistently show that PSWs remain underutilized. Although research addresses several factors that influence the formal implementation of their role, there is a lack of a comprehensive framework that synthesizes the factors and addresses their interlevel interactions. This paper provides a narrative review and synthesis of the literature on multilevel factors that influence formal PSW role implementation in mental health systems. We conducted a search of literature and reviewed 38 articles that met inclusion criteria. Our thematic analysis involved identifying first and second-order categories that applied across studies, and developing third-order interpretations through iterations. We synthesized the findings in a multilevel framework consisting of macro, meso and micro level influences. Influencing factors at the macro level include broader socio-cultural factors (medical model, recovery values, professional power dynamics, training and certification), regulatory and political factors (policy mandates, political commitment), and economic and financial factors (funding, affordability of services). Factors at the meso level include organizational culture, organizational leadership, change management, and human resource management policies. Micro level influences pertain to relationships between PSWs and team members, and PSW wellbeing. Interlevel interactions are also outlined. Limitations and implications for research, policy and practice are addressed.

Keywords: Peer support, Role implementation, Mental health, Multilevel framework, Narrative review

INTRODUCTION

Research has increasingly shown that peer support plays an important role in mental health systems (Byrne et al., 2016; Gillard et al., 2015; McCarthy et al., 2019; Otte et al., 2020b). Health systems in various countries such as the US, Canada, UK and Australia are increasingly recognizing the role of peer support workers (PSWs) in mental health services (Commonwealth of Australia, 2013; Cyr et al., 2016; Department of Health (DH), 2012; SAMHSA, 2021). However, studies consistently show that PSWs remain underutilized in formal mental health systems because of various barriers and influences on the implementation of their role (Otte et al., 2020a). This paper provides a narrative review of the literature on the multilevel influences on peer support role implementation.

A peer supporter in mental health is a person who has lived experience of mental health issues and offers support or services to others with mental health issues. Peer support is "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (Mead et al., 2001, p. 135). Solomon (2004) categorizes peer support into four groups ranging from voluntary to formal, specifically: self-help groups, peer-run services, peer partnerships, and peer employees. The focus of this paper is on peer employees or paid peer support workers (PSWs), who—unlike those who engage in voluntary peer support—hold formal roles in mental health/social services organizations. PSWs provide services in a variety of settings that include hospitals, community health centres, and transitional programs (Gillard et al., 2020; Repper & Carter, 2011; Vigod et al., 2013).

PSWs can be role models for recovery for other individuals experiencing mental health issues (Cyr et al., 2016; Rebeiro Gruhl et al., 2016). PSWs' engagement with peers tends to differ from professionals' engagement; for example, PSWs are able to establish stigma-free relationships with hard-to-reach populations (Ibrahim et al., 2020; MacLellan et al., 2017). PSWs may be called certified peer specialists (Grant et al., 2012), peer support providers (Asad & Chreim, 2016; Moll et al., 2009), advisors (Agrawal et al., 2016), or other terms.

The literature points to several potential contributions of peer support including fostering recovery and hope for people suffering from mental health issues, connecting with hard-to-reach populations, supporting a smooth transition from hospital to community, and changing perceptions of stigma (Asad & Chreim, 2016; Ibrahim et al., 2020; MacLellan et al., 2017; Mulvale et al., 2019). It has been pointed out that peer support lowers symptom distress and improves quality of life (Cyr et al., 2016) and that supplementing mental health services with peer support significantly reduces re-hospitalization (Sledge et al., 2011), hence reducing the overall cost of service. Although some authors have indicated that there is a paucity of quality evidence on the effectiveness of peer support (Chinman et al., 2014; LaFrance et al., 2017; Lloyd-Evans et al., 2014), a few studies have attempted to provide some evidence. For example, a randomized clinical trial that integrated peer support in a transitional discharge model of care with clients who have a chronic mental illness found that the intervention participants with peer support had been discharged an average of 116 days earlier per person (Forchuk et al., 2005). Overall, despite its benefits to mental health care, peer support is not well integrated within mainstream mental health services (Rebeiro Gruhl et al., 2016). This paper addresses the influences on (lack of) integration of the PSW role.

These influences manifest at the health systems and policy level, organizational level, and team/individual level. Although research addresses several of these factors, there is a lack of a comprehensive framework that synthesizes them and addresses their interlevel interactions. Gillard finds the current PSW evidence base "frustratingly messy" (Gillard, 2019, p. 343). Further, in the absence of a multilevel review, it is difficult to understand how factors at various levels interact to compound the obstacles or enablers to the implementation of the role. This paper draws on a multilevel perspective to provide a narrative review of the literature on macro, meso and micro level factors that influence the implementation of the PSW role in mental health care. The research question is: what are the multilevel factors that influence the formal implementation of the PSW role in mental health care and how do factors interact across levels?

Application of a multilevel perspective has enabled a better understanding of factors that influence the implementation of changes in roles, practices, groups, and organizations in health systems (Chreim et al., 2007; Kooij et al., 2018; Nelson et al., 2014; Smith et al., 2019). With respect to influences on the implementation of the PSW role specifically, some studies have adopted the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009). This framework offers five levels of investigation including technology-related factors; outer setting (e.g. policy); inner setting (e.g. resources in an organization); process (e.g. engagement of stakeholders); and individual health professionals (e.g. individuals' knowledge). Siantz et al. (2016) applied CFIR in an empirical investigation and Ibrahim et al. (2020) used it in a systematic review to identify barriers and facilitators to PSW role implementation. These are highly informative studies, but the influences they consider are mostly at the individual, group and organizational levels. Less attention has been directed to the system level influences (e.g. the

policy environment, societal norms) and to the interactions between factors operating at different levels.

Yet "organizational phenomena unfold within complex and dynamic systems" that are influenced by the broader environment (Hitt et al., 2007, p.1385). Multilevel thinking is essential in understanding these "nested arrangements" (Hitt et al., 2007, p.1387). A multilevel perspective also facilitates understanding of interlevel dynamics (i.e. how factors on one level interact with factors at another level). Interlevel analysis allows researchers to build theoretical and empirical bridges across levels and tackle "real-world problems" (Hitt et al., 2007, p.1395). Since the focus on one level might prevent adequate attention to other levels and also overlook their interactions, researchers have examined not only multilevel influences, but also interlevel interactions. For example, Chreim et al. (2007) tracked the reconstruction of the professional role identity of physicians by focusing on influences in the environment external to the organization (macro level), organizational influences (meso level), and individual influences (micro level), and by considering their interactions. In this paper, we adopt a multilevel perspective in our review of the literature on factors that influence the implementation of the PSW role in mental health services. We also address interlevel interactions.

METHODS

In this review, we adopted a narrative approach and conducted an interpretive synthesis of the literature (Greenhalgh et al., 2018) on influences on PSW role implementation. This type of review is particularly useful for this study because it not only involves the identification of themes (the influencing factors) in the literature, but also allows the achievement of synthesis through subsuming concepts in published studies into a more abstract or higher-order structure

(Dixon-Woods et al., 2005). A narrative review allows reflexive description and critique of the findings from extant literature (Greenhalgh et al., 2018). A narrative review—similar to an integrative review (Whittemore and Knafl, 2005)—can examine a phenomenon by using diverse empirical, theoretical, and methodological literature; it need not be limited to primary empirical studies. Our review included quantitative and qualitative research as well as reviews, which allowed us to rely on and synthesize different evidence types (Dixon-Woods et al., 2005). Since a narrative synthesis often includes a systematic way of searching the literature (Dixon-Woods et al., 2005; Greenhalgh et al., 2018; Major & Savin-Baden, 2010), we followed the procedures outlined below.

Literature Search

Database search: Two researchers conducted a search of the literature and performed iterative screening for the inclusion of papers. Online search was from academic databases, including CINAHL (Ebsco), Scopus, MEDLINE (Ovid), PsycINFO (Ovid), and Web of Science. The online database search was guided by a librarian to retrieve the most relevant published articles from each database. The search was filtered for only English language papers and those from 2000 to 2020. The search strategy included three components: (1) peer support, (2) role implementation/integration, and 3) mental health. The search string included synonyms or subject terms related to these phrases and used Boolean operators. The string was edited based on the specifications of each database in order to capture the papers in the same way. For example, ("peer support" or "peer support worker" or "peer provider" or "peer specialist") AND (role and integration or implement or integrate or implementation) AND ("mental health" or "mental illness" or "mental disorder" or "psychiatric illness"). The search resulted in 689 papers

(including duplicates). An additional 8 papers were identified through hand search, reading references, or other sources. Overall, 380 records remained after duplicates were removed.

Selection of Studies for Review

After removing the duplicates, a pilot screening of all the article titles and abstracts was performed by two reviewers using primary inclusion criteria. The reviewers used Covidence, a web-based software platform for teams coordinating their work on reviews (Veritas Health Innovation, Melbourne, Australia; www.covidence.org). Conflicts were carefully discussed, and a final list of inclusion and exclusion criteria was reached (Table.2-1). Using the refined criteria, the reviewers conducted a second abstract screening that yielded a smaller number of conflicts (16 papers), all of which were resolved through a second conflict resolution session. Papers relating to the context of forensic mental health services were removed because of the specificities of this context (regulations, funding, organizational factors) that do not apply to mental health services more broadly. The process of reviewing papers was then followed by eligibility screening of the full texts and quality assessment described below (55 papers). Finally, 38 papers were included in the review.

Table 2-1

Inclusion and exclusion criteria

Inclusion criteria	**Peer-reviewed full-text articles published in English during (2000–2020) that meet all the following criteria:** **Paid/employed PSWs who provide intentional peer support, exclusive of voluntary, unpaid peer support.** **A broad range of mental health services including behavioral health topics that overlapped with mental health and substance abuse.** **Explicit indication of implementation, integration, or management of PSW role in mental health systems or settings**
Exclusion criteria	Excluded if one or more of the following criteria are met: PSW interventions in areas other than mental health, e.g., neonatal care, diabetes, and other illnesses Mental health settings other than community or inpatient settings accessible to the public, for example, secured forensic mental health settings Editorials, conference proceedings, dissertations PSW role implementation under COVID-19 conditions

Tools and Techniques

Search flow diagram: A PRISMA Flow Diagram (2009) illustrates the steps taken during the literature search and the number of articles included at each step based on the inclusion criteria below.

Inclusion and exclusion criteria: The criteria we used—outlined in Table 2-1—determined the selection of papers at each stage (Fig 2-1).

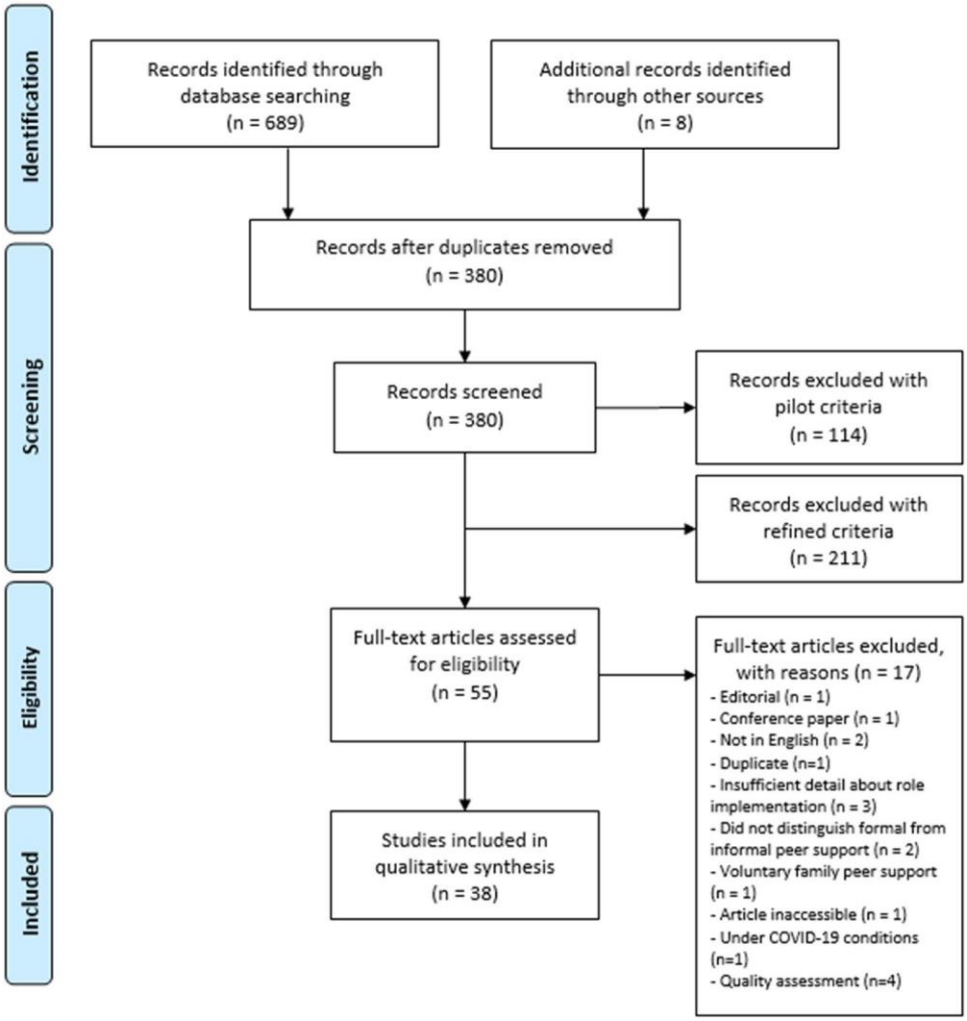

Fig. 2-1

PRISMA flow diagram

Quality Assessment

There is disagreement in the literature on whether quality of articles should be evaluated, and on the approach that needs to be used should one decide to evaluate quality (Dixon-Woods et al., 2005; Greenhalgh et al., 2018). Our approach was to include only articles that were published in peer-reviewed indexed journals with an impact factor or a Scopus CiteScore. We also conducted a quality appraisal that was informed by the McMaster University critical appraisal forms (Law et al., 1998; Letts et al., 2007). The forms determined quality, considering such

criteria as identification of study purpose, review of relevant literature, details on methods (such as study design, sampling, data collection, analyses and overall rigour), results, implications for research and practice. We evaluated each paper using the assessment criteria and ranked it using a scale of strong, moderate, and weak. Papers evaluated as weak were removed.

Figure 2-2, based on the included papers, shows increasing attention to and growing importance of research on PSW role implementation.

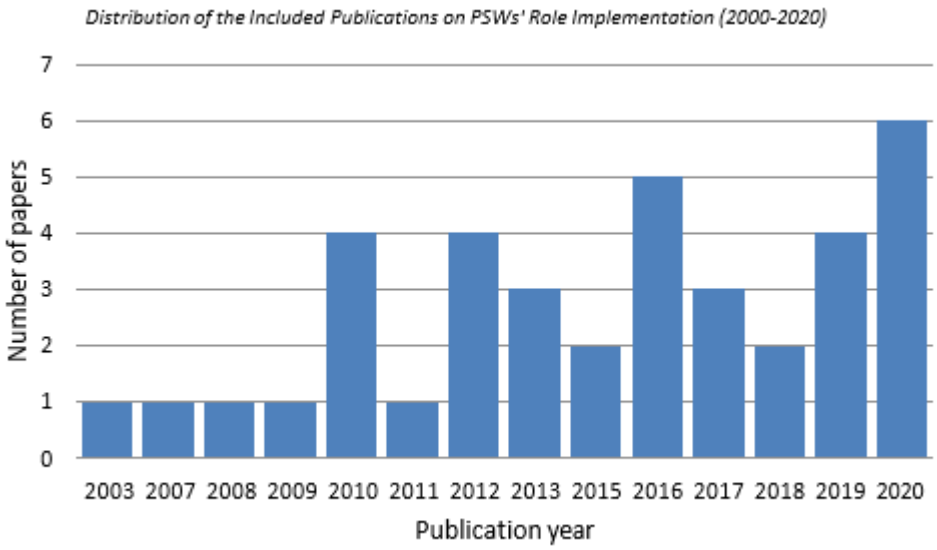

Fig. 2-2

Distribution of the included publications on PSW role implementation (2000–2020)

Data Analysis

Our reading of extant research on factors that influence implementation of PSW role was similar to other researchers who have found the literature dispersed and fragmented (e.g. Gillard, 2019). Hence our goals were to organize and integrate. We adopted a multi-level perspective to achieve both these goals. Other researchers have used multilevel frameworks to study influences on role and change implementation (e.g. Chreim et al., 2007; Kooij et al., 2018;

Nelson et al., 2014; Smith et al., 2019) and we were inspired by their work. Using a mixture of deductive approach (based on the frameworks proposed by multilevel authors) and inductive approach (based on our reading of the data we were working with), we developed a framework that distinguishes between macro, meso and micro level factors. We designated influences that operate in the external environment of organizations and that tend to be outside of the control of organizations as macro level influences. These were influences operating at the health system, societal or national economic levels, for example. Influences at the meso level are within a certain level of control by the organization. These influences are relevant across departments and go beyond a small team or single individual. At a lower level of analysis, we find influences of a micro nature that involve team and individual behaviors and dynamics that influence the role implementation. We would like to point out that our review and the framework we adopted involves interpretation, as do all types of syntheses (Dixon-Woods et al., 2005). A narrative synthesis is a flexible and effective way to develop themes that bring coherence to separate data from a body of evidence (Briner & Denyer, 2012; Popay et al., 2006).

Our analysis involved reviewing each paper and deriving themes that we allocated to the various levels. For example, we considered influences related to health policy to operate at the system level and we designated them as macro level influences. We followed the recommendations of Miles, Huberman and Saldana (2020) in our analysis. As they advised, themes were amended and recategorized as the analysis progressed. The process was not linear and included iterative loops in thematic analysis (Major & Savin-Baden, 2010; Miles et al., 2020). For example, in the early steps, we had identified *change management* as a meso level theme that included the topic of *organizational leadership*. After further analysis, the notion of organizational leadership emerged as a central factor that influences PSW role implementation,

and it became evident to us that organizational leadership could be separated from change management and discussed as a theme on its own. Similar iterative processes allowed us to refine the various themes and subthemes (Miles et al., 2020).

According to Major and Savin-Baden (2010), synthesis means "taking parts and developing them into a new whole" (p.64). It involves combining themes across the studies, identifying second order categories across studies, and developing third order interpretations (Major & Savin-Baden, 2010). Using constant comparisons, we synthesized and clustered themes into larger categories. For example, we reflectively clustered *dominance of the medical model in mental health care* and *professional power dynamics* into a second order category that we called macro socio-cultural context. Our analysis also involved considering how factors at one level could influence factors at the same or another level. Throughout the synthesis, we discussed interpretations to establish the plausibility of the findings (Major & Savin-Baden, 2010; Greenhalgh et al., 2018). The final product of our analysis—a multi-level framework that summarizes the influences and the interlevel interactions—is provided in Table 2-2.

Table 2-2

Multilevel factors influencing peer support workers role implementation

Levels of analysis	Themes in each level	Sub-themes/details	Inter (downward) & intra-level influences
Macro level **Systems and broader structures level** Source of role legitimacy & professional power dynamics	Macro socio-cultural factors	Discourses on medical model and recovery approach Professional power dynamics Training and certification	Macro: Regulatory and political factors Macro: Economic and financial factors Meso: All themes Micro: Relationships with team members
	Regulatory and political factors	Policy mandates Political commitment	Macro: Macro socio-cultural factors Macro: Economic and financial factors Meso: All themes Micro: Relationships with team members
	Economic and financial factors	Historical influence of voluntary work Financial structures in health systems (funding) Economic uncertainty	Meso: Human resource management policies
Meso **level Organization level** Arrangements affecting role implementation in mental health organizations	Organizational culture	More or less hierarchical culture Role clarity or ambiguity	Meso: Leadership and supervision Meso: Human resource management policies Micro: Relationships with team members
	Organizational leadership and supervision	Commitment of organizational leadership Commitment of supervisors	Meso: Organizational culture Meso: Human resource management policies Micro: Relationships with team members
	Change management & workplace strategy	Change management model Consultation of various stakeholders Workplace integration strategy	Meso: Organizational culture Meso: Human resource management policies Micro: Relationships with team members
	Human resource management policies	Hiring criteria and procedures Remuneration of PSWs Training & socialization Retention Access to resources (self-care & education, network of PSWs, physical resources)	Meso: Organizational culture Micro: Relationships with team members Micro: PSW wellbeing

Levels of analysis	Themes in each level	Sub-themes/details	Inter (downward) & intra-level influences
***Micro* level** **Integration to mental health teams** Interactions of PSWs and staff in teams and the experiences of PSWs navigating their role in the teams	Relationships with team members	Stigma (various types) Readiness for the integration of PSWs in mental health teams) Role boundaries (disclosure of PSWs mental illness information & disclosure of peers' information to the team)	Micro: PSW wellbeing
	PSW wellbeing	Emotional involvement Self-care	

RESULTS

Factors that Influence PSW Role Implementation

In this section, the literature on factors influencing PSW role implementation is reviewed. Table 2-2 shows the factors at each level and reflects the interlevel influences. It is important to note that the themes we report are not mutually exclusive. Separating themes is necessary for presentation purposes, but as our analysis will show, a factor can operate at various levels, as well as intralevel.

Factors at the Macro Level of Analysis

Factors at the *macro level* pertaining to PSW role implementation relate to the macro socio-cultural context, the regulatory and political context, and the economic and financial context.

Macro socio-cultural context

Literature shows that *dominance of the medical model* in mental health care and *professional power dynamics* influence PSW role implementation. The medical model culture that prevails in mental health services is a major barrier to recovery-focused approaches and to PSW role implementation (Byrne et al., 2016). This culture privileges a hierarchical structure whereby power lies in having a medical or clinical background (Ehrlich et al., 2020). Tensions exist

between the view of those in favor of peer support and the traditional view based on the medical approach. These tend to be opposing discourses, and Byrne et al. (2016) refer to such opposition as two worlds colliding (p. 217). While advocates of peer support rely on the principles of recovery, experiential knowledge, and the philosophy of self-determination and empowerment (Gillard et al., 2017), the medical model has an emphasis on the "expert knows best" attitude, medication treatment, therapy, and other highly regulated services (Byrne et al., 2016, p. 220).

The medical model and the "expert knows best" approach encourage power imbalances in favor of organized professions (Byrne et al., 2016). Peer support is based on personal relationships and caring, and PSWs' effectiveness depends on quality of relationship and mutual trust that they establish rather than use of knowledge obtained by academic qualifications (Repper & Carter, 2011). However, established professions show resistance to PSWs' practice through prejudice, stigma, and discrimination (Walker & Bryant, 2013), hindering the implementation of PSW role. Byrne et al. (2019) refer to the "institutionalized discrimination" towards people with a history of mental illness in Australia and "prejudicial attitudes" from the mental health professions that inhibit the PSW role development. Such discrimination has been observed in other jurisdictions as well such as Canada (Mulvale et al., 2019).

Despite enduring dominance of the medical model, there has been increasing attention to recovery-oriented approaches and acceptance for the role of PSWs (as we show in the next section). This has accompanied attention in several jurisdictions to developing training programs to enhance the competencies of PSWs and to provide certification (Rebeiro Gruhl et al., 2016). Hence, PSWs can be formally certified allowing their qualifications to be recognized in the mental health system as has been the case in many states in the US (Grant et al., 2012). Certification is also available in other countries, such as Australia (Fan et al., 2018) and training

programs have become more common (e.g. several European countries, Japan) (Berry et al., 2011; Burr et al., 2020; Matsui & Meeuwisse, 2013). Training and certification help enhance the legitimacy of PSWs in an otherwise professionalized domain and can facilitate their integration into the mental health system.

Regulatory & political context

System-level policies have influenced the implementation of PSW role in mental health care through downward directives. In the US, there have been state and federal health care policies that mandate mental health centers hire PSWs called "certified peer specialists" (Grant et al., 2012). Grant et al. (2012) showed successful integration of the PSW role in these settings. In Canada, the Mental Health Commission of Canada has recommended the development of peer support in mental health care, however, the integration of PSW role in clinical settings has remained a challenge (Mulvale et al., 2019), showing that recommendations by high level bodies are helpful but likely not sufficient. This is in contrast to stipulations that the inclusion of peer specialists is a requirement in Assertive Community Treatment (ACT) teams in some Canadian provinces such as Ontario (White et al., 2003).

In the UK, the policy decision to include recovery in frontline services resulted in the creation of a peer support worker role by the NHS that has been distinct in terms of offering mutuality, empowerment, modeling hope, and the sharing of lived experience with peers (Gillard et al., 2015). PSW role implementation in the NHS has also led to enactment of occupational health practices, staff training, and other measures such as developing referral processes (Berry et al., 2011; Creamer et al., 2012).

High level regulation can target various areas of PSW employment, including, for example,

recruitment, working hours and pension. Burr et al. (2020) found that PSWs in Switzerland work 35% of a full-time equivalent (13 h per week) because mental health organizations had no legal obligation to employ PSWs. In Ontario, Canada, the Ministry of Health requires 0.5 full-time-equivalent paid staff in a PSW position in Assertive Community Treatment Teams and PSWs have been consistently recruited throughout the province (White et al., 2003). Directives from higher levels of authority on recruitment and remuneration policies enable the integration of PSWs in mental health organizations.

In Australia, policy mandates to include people with lived experience started in the 1990s, and ever since, government plans and standards have recognized the employment of PSWs (Byrne et al., 2019) and have advocated for the employment of lived experience roles as essential to the implementation and development of recovery-orientated service delivery (Byrne et al., 2019; Franke et al., 2010). Despite this policy environment, challenges persist in Australia because of prevalence of the medical model and tokenism of lived experience (Byrne et al., 2016; Ehrlich et al., 2020), indicating that policies that are not accompanied by changes in the dominant views in the social/cultural environment may lead to compliance but not genuine change in terms of embedding peer support in the mental health system (Siantz et al., 2016). The importance of increasing political commitment has been highlighted as a means to develop legal requirements and stipulations that are favourable to PSW role integration in the mental health system (Burr et al., 2020). These legal requirements in turn help legitimize the PSW role as an integral part of the system. However, the literature also calls for caution so as not to tightly regulate or prescribe the PSW role, pointing to potential disadvantages and explaining that peer support involves inherent creativity and flexibility in the role, which enables PSWs to provide individualized support (Asad & Chreim, 2016; Berry et al., 2011; McCarthy et al., 2019).

Economic & financial context

Providing financing for PSWs' services has been an influencing factor, and countries that have accounted for peer support services in the financial structure of the health system have been able to integrate the PSW role in mental health care (Grant et al., 2012). For example, several states in the US have provided Medicaid reimbursement for services of certified peer specialists and paved the way for PSWs to be formally employed (Grant et al., 2012). Literature shows that system-level funding support enables financial arrangements for PSWs within mental health organizations, e.g., through funding for embedded peer support programs in mental health care or the development of training opportunities (Davis et al., 2010; Ibrahim et al., 2020). Research also indicates that PSW services create a *social return on investment* and emerging evidence supports the economic justification of investing in the recovery-focused services that they provide (Ibrahim et al., 2020).

Despite the relative affordability of services of PSWs, obstacles remain to formal integration of their role in mental health systems, due in part to enduring patterns and established views. Peer support comes from a history of consumer-run movement (eighteenth century in Europe and during the 1970s and 1980s in North America) which is founded on naturally occurring, voluntary peer support (Ibrahim et al., 2020; Mulvale et al., 2019). Therefore, PSWs have a long history of not being paid for the services they offer. The interlevel impact of a history of voluntary work is reflected at the level of organizations, where there tends to be absence of pay scale and other HR policies related to PSW remuneration (Hebert et al., 2008; Ibrahim et al., 2020; Wall et al., 2020). This reflects a relative devaluation of the PSWs' skills within the hierarchy of occupations in mental health care (Asad & Chreim, 2016).

Other high level economic factors such as national economic uncertainty can pose barriers

to funding that can secure PSWs' employment. For example, in the US, the 2008 economic crisis budget cuts could jeopardize PSWs' position mainly because Medicaid funding could be eliminated for services of the certified peer specialists (Grant et al., 2012). Economic uncertainty as an influencing factor is a topic that has not received sufficient attention in the literature.

In sum, impediments to implementation of the PSW role in mental health care systems include dominant and enduring structures and discourses on mental heath care that favor the medical approach and professional designation in service delivery, discrimination against and lack of understanding of the value of recovery for mental health, and economic uncertainty that leads to cuts in mental health services. However, in various jurisdictions, there appears to be a shift in views and increasing recognition of the value of peer support, the provision of training and certification that enhance the legitimacy of the role, changes in policies and regulations, and increased financing that enable integration of the PSW role in the mental health care system.

Factors at the Meso Level of Analysis

Factors at the *meso* level include organizational culture, organizational leadership, change management and workplace strategy, and human resource management policies.

Organizational culture

Peer support services are offered within organizations that have different organizational cultures. Literature often refers to common challenges relating to PSWs' integration into more hierarchical organizations—challenges that include lack of appropriate supervision (Creamer et al., 2012; Gopalan et al., 2017) and unclear role definitions, accountability, and boundaries (Byrne et al., 2019). These organizations tend to show apprehension relating to PSWs' access to peers' medical records (Chinman et al., 2010).

Comparative studies including organizations with more or less hierarchical cultures have been conducted to identify how contextual factors influence PSW role implementation. In a study in the US, Moran et al. (2013) found that contextual factors that create challenges to the PSW role differ between "conventional" mental health settings (e.g., ACT teams) and consumer-run agencies. They showed that challenges for the employed PSWs in conventional mental health services that are run by non-peers include direct and indirect expressions of prejudice, lack of recovery focus, and being the only PSW in the organization. A comparative case study in the UK showed that expectations related to the role of PSWs vary across organizations (Gillard et al., 2015). This study showed that in organizations with a structured and hierarchical culture, the distinctiveness of the PSW role in bringing a "meaningfully different practice" was undermined as the expectations from the PSWs were that they demonstrate roles similar to existing health care roles that have "clinical-like boundaries" (p.690). Hence the role became constrained, and when its implementation was an early decision with lack of understanding of the role in the team, staff resistance occurred. In contrast, the PSW role maintained its distinctiveness in organizations with a solid collective understanding of the role and a culture supportive of peer work (Gillard et al., 2015).

Organizational leadership and supervision

Commitment of organizational leadership has been found to be an important factor in preparing the organization for implementation of PSW role and supporting PSWs in integrating into mental health teams (Franke et al., 2010). As indicated above, at the macro level, policy leaders can offer opportunities for training, certification, and funding for PSW positions at a health systems level, and can create systems for evaluation of peer support programs (Mulvale et al., 2019); in turn, organizational leaders can build upon the macro system-level foundation

and implement strategies that include recovery-oriented principles to facilitate integration of PSWs in mental health teams.

Support from senior organizational leaders enables changes in services when a PSW role is introduced, especially where a clinical setting is new to the role and needs orientation on importance of and practices associated with lived experience (Hopkins et al., 2021). Leaders can provide a vision for integration of PSWs as part of person-centred care teams and offer education about the PSW role and its benefits "while recognizing that adoption of peer support requires a culture change that takes time" (Mulvale et al., 2019, p.72). Organizational leaders can alter organizational policies and set goals to move beyond medically focused services and to include recovery-oriented services that enable employment of PSWs (Byrne et al., 2016). They can also facilitate hiring and training of PSWs (Chinman et al., 2012; Gates et al., 2010; Shepardson et al., 2019).

Educating immediate supervisors of PSWs about the role can also facilitate integration since supervisors "broker" the relationship between the organization and PSWs and between the PSWs and co-workers (Kuhn et al., 2015). The importance of supervision is strongly highlighted in the literature and has been associated with "success" and sustainability of peer support programs (Creamer et al., 2012; Gopalan et al., 2017; Kemp & Henderson, 2012; Siantz et al., 2016; Walker & Bryant, 2013).

Change management and workplace strategy

Implementing the PSW role often requires that the mental health organization demonstrate openness to change, especially when the culture and dominant views at the organization are not supportive of recovery practices or incorporating lived experience as part of mental health care

services (Berry et al., 2011). Research shows that mental health organizations can benefit from a *change management model*. Such model would consider system level policies, strategies and changes and translate them at the organization, practice, and individual levels (Mulvale et al., 2019). Alignment with supportive national and regional level government policy directives can help mental health organizations better implement the PSW role (Hopkins et al., 2021).

Chinman et al. (2010) describe a multi-step approach used successfully in the VA (Veterans Affairs) mental health system. It entailed consultation and solicitation of those involved in the peer role implementation and consisted of several steps, namely exposure (providing information and discussion on the role), adoption (leadership decision and subsequent support for the role implementation), implementation (trial use of PSWs and refinement of the role based on discussions and decisions). Franke et al. (2010) provide another example of a change model. Spearheaded by South Australian Department of Health, the Peer Work Project was launched for training and sustainable employment of PSWs. This project suggested a model (prepare, train, support) as a tool for the introduction of formal PSWs at the employing organization. The model included a segment on organizational preparation (including role definition, training staff, developing policies, procedures, and induction processes) and followed with organizational support (including supervision, staff meetings, and workplace mentoring) to achieve sustainable employment for trained PSWs (Franke et al., 2010). This program shows how directives and programs enacted at the system level can be taken up by organizations intent on change that supports the implementation of the PSW role.

Consultation of various parties involved in the change, such as supervisors, clinicians and PSWs paves the way to achieve better integration (Gates & Akbas, 2007; Gillard et al., 2017; Otte et al., 2020a; Shepardson et al., 2019). It has also been pointed out that PSW role

development and integration can be an ongoing process involving proactively monitoring and removing challenges (Chinman et al., 2012). Evidence points to a *workplace strategy* alongside change management to effectively promote the PSW role integration (Gates et al., 2010; Gillard et al., 2017). A workplace strategy that develops a comprehensive peer support program structure and appropriate human resource policies enables the sustainability of PSWs' role (Gillard et al., 2017; Kuhn et al., 2015).

Human resources management policies

The literature refers to organizational policies on hiring, remunerating, training and socializing, and retaining PSWs as enabling or hindering PSW role integration.

With respect to *hiring*, the literature shows the importance of establishing criteria for the recruitment of PSWs. A research project in the VA in the US called Peers Enhancing Recovery demonstrated potential for integration of PSWs in case management teams (Chinman et al., 2012). The findings showed that the Human Resources department, based on past experience with hiring professionals, often did not know how to utilize lived experience as a hiring criterion, causing confusion and preference to hire individuals with credentials other than lived experience. Organizational guidance on how to utilize PSWs is identified as a factor that supports placing PSWs in work roles that are centered around lived experience and helping others in recovery (Mancini, 2018). Development of a program structure for the integration of PSWs' role rather than siloed recruitment of PSWs on an ad-hoc basis (Hebert et al., 2008; Frank et al., 2010; McCarthy et al., 2019) also enables role implementation.

(Mis)understanding of the importance of lived experience impacts the *remuneration* of PSWs. Remuneration is a gauge for the level of education, expertise, and hierarchy of positions

in mental health organizations (Asad & Chreim, 2016; Ibrahim et al., 2020). Inadequate remuneration and limited workplace resources give the impression that the skills of a PSW are not valued (Asad & Chreim, 2016; Vandewalle et al., 2016). Literature shows that interprofessional power dynamics that manifest at the system level also appear at the organizational level when considering remuneration disparity (Burr et al., 2020; Repper & Carter, 2011). Findings show that an appropriate "pay scale classification" for PSWs (Otte et al., 2020a) that fairly values their contribution to the wellbeing of the service users (Gates & Akabas, 2007) is essential for the formal integration of PSW roles in mental health organizations.

Training offered by organizations also enables PSWs' integration into mental health services. Asad and Chreim (2016) found that there are different types of training that enhance PSW role integration, including training that is offered to all staff as a socialization process, workshops specific to peer support services, and ongoing learning opportunities during the job. In addition, training may be delivered through several contributors who all agree to provide a holistic and continuous training experience to the PSWs (Chinman et al., 2010). For example, in the VA in the US, training is provided by other employed PSWs, other staff from mental health intensive case management through shadowing, and/or contractors who train for specific mental health programs (Chinman et al., 2010).

Training for PSWs and mental health teams holds several benefits. First, PSWs tend to develop their sense of professional identity and a more distinct role as they differentiate their strengths from other mental health workers (e.g. their unique relationship with peers, having authentic empathy and a normalizing function, and a "different sort of creativity" in working with the peers [Berry et al., 2011]). Wall et al. (2020) identified that PSWs showed high intrinsic

motivation and high self-efficacy after training. Second, training alleviates potential conflicts in mental health teams by improving teams' tolerance and acceptance for PSWs' work practices (Berry et al., 2011; Matsui & Meeuwisse, 2013; Rebeiro Gruhl et al., 2016). Training PSWs and teams lessens potential discrepancies (experienced by both the PSWs and the teams) between the job description presented at the recruiting interview, and the reality of the PSWs' role (Berry et al., 2011; Davis et al., 2010; Gates et al., 2010). Mancini (2018) found that it was essential and important for PSWs to seek ongoing professional development opportunities and continuing education similarly to other "helping professions" that are mandated to keep skills up to date. The author pointed to the need for career advancement with incremental pay and ranks that reflect skill level and experience and that these various methods "would allow them greater legitimacy and bargaining power within traditional mental health organizations" (p.132).

In addition to training, organizations can facilitate PSWs' *self-education and access to resources.* One such resource is access to material or workshops that help PSWs understand the technical terminology typically used in mental health settings (Asad & Chreim, 2016; Ibrahim et al., 2020). Other resources become available when organizations hire simultaneously or employ multiple PSWs as this can offer a *network of peers;* this empowers PSWs to discover their strengths and to support each other through collegial consultation (Berry et al., 2011; Burr et al., 2020; Gillard et al., 2017; Wall et al., 2020). The Peer-to-Peer Resource Center in VA is an example of a PSW network for continuous training and support on general peer support skills (Chinman et al., 2010).

Another organizational human resource policy that enables integration of PSW role refers to *sick leave* as part of PSW employment. In the VA in the US, for example, a sick leave policy is applied for the employed PSWs in the same way that it applies to other staff (Chinman et

al., 2010). Human resources policies that enable integration of PSWs would also benefit from looking ahead at *retention*. Retention of PSWs relates to providing not only proper remuneration (fairly balanced between workload and compensation (Wall et al., 2020), training, and job development opportunities, but also physical resources such as a computer and an office to meet with peers (Burr et al., 2020; Ibrahim et al., 2020; Moran et al., 2013). Comprehensive human resources policies that acknowledge the value of the skills and work of PSWs enable integration and sustainability of the role.

In sum, the following facilitate the implementation and the sustainability of the PSW role: a supportive organizational culture, leadership commitment at all levels of the organization that signals the importance of lived experience and recovery in mental health services and supports the implementation of the PSW role, adoption of change management and workplace strategies, and finally, enacting comprehensive human resources policies.

Factors at the Micro Level of Analysis

Micro level influences on PSW role implementation include the relationships with team members and (in)ability to achieve wellbeing.

Relationships with Team Members

Tensions in relationships with other mental health staff have limited PSWs' integration into mental health teams (Otte et al., 2020a). These tensions are partly because of a lack of trust in and understanding of the experiential knowledge of the PSWs (Ibrahim et al., 2020). Literature highlights that PSWs find *stigma* prevalent and a "normal" part of their job in mental health care, which is ironic given their vital contribution to stigma reduction (Byrne et al., 2019; Mancini, 2018).

PSWs may experience various forms of stigma. They experience *structural stigma* that emanates from lack of HR policies (as mentioned above) related to PSWs. There are cases where PSWs do not have the same privileges at work as their non-peer colleagues e.g., career development and other employment benefits (Mancini, 2018; Siantz et al, 2016). PSWs also experience *stigma relating to stereotypes* about mental illness that negatively affect health professionals' attitude and lead to discrimination towards the PSWs (Byrne et al., 2019; Otte et al., 2020a). The reflection of such attitude is evidenced as "direct and indirect expressions of prejudice" (Moran et al., 2013, p.284). PSWs may experience prejudice from the staff in general, and especially in cases when the PSW transitions from a "patient" to a PSW (Moll et al., 2009). In the case of colleagues who had previously treated the PSW, negative attitudes can manifest in absence of courteous collaboration (Ibrahim et al., 2020; Walker & Bryant, 2013). As such, PSWs can experience exclusion from meetings or lack of reciprocal communication with the other staff that hinder PSW integration within teams (Byrne et al., 2016; Shepardson et al., 2019).

Research findings show that a low "readiness" level of the PSWs and the non-peer staff for the integration of the PSW role in the team play a significant part in the PSWs' experiences of stigmatization (Mancini, 2018). PSW integration within teams may happen gradually as attitudes shift and team members develop an understanding of the role (Asad & Chreim, 2016; Ehrlich et al., 2020; Mulvale et al., 2019; Tse et al., 2017). Findings of a peer support project in Hong Kong (Mindset project) showed that despite the uncertainty about the PSW role at the beginning of the implementation, staff progressively developed trust and awareness about the role and changed their perception of peer support services to a point that they viewed PSWs as an "*asset"* both for the staff and the peers (Tse et al., 2017)

Another aspect of relationships with other staff that may influence integration is PSW

disclosure of details about their own mental illness to the teams, which can be experienced as a challenge by the PSW (Chinman et al., 2010; Gates et al., 2010; Kemp & Henderson, 2012). Literature points to cases when mental health teams (e.g. Mental Health Intensive Case Management for the veterans in the US) strongly agreed on hiring PSWs who are comfortable disclosing about their mental illness and sharing their recovery experience (Chinman et al., 2010). This can enable integration of PSWs by helping them build trust with team members, although—as we have argued above—for this approach to be effective, there needs to be acceptance of the value of lived experience and belief in recovery on the part of team members.

There are other disclosure issues that can create challenges for the integration of PSWs within teams and which concern PSWs' sharing of information on the peers (or service users) with the other staff (Asad & Chreim, 2016; Kemp & Henderson, 2012; Moll et al., 2009; Repper & Carter, 2011). PSWs' effort of maintaining a balance between their commitment to providing support for their peers and the expectations of the mental health professionals to obtain information on clients is an enduring challenge (Ehrlich et al., 2020; Otte et al., 2020a). Sharing insights and achieving agreement on peer information disclosure within the team enables PSW role integration (Gillard et al., 2017; Repper & Cater, 2011). Overall, issues related to defining the role boundaries of PSWs can impact whether role integration is hindered or enabled (Asad & Chreim, 2016).

PSW Wellbeing

Maintaining PSWs' wellbeing is another micro factor that enables role implementation. This is an important issue for PSWs because of potential for being burdened when engaging in peer support (Otte et al., 2020a, 2020b; Vandewalle et al., 2016). There are also issues of managing the boundaries with the peers that include for example, after-hours involvement,

friendship vs. friendly behavior, and setting a distance (Chinman et al., 2010; Otte et al., 2020a; Rebeiro Gruhl et al., 2016). Interactions with the peers may lead to emotional involvement or attachment and PSWs need to manage their feelings at the end of their professional relationship (Moran et al., 2013; Vandewalle et al., 2016). Evidence suggests that access to self-care, training, and supportive supervision can help address some of these concerns (Chinman et al., 2010; Davis et al., 2010; Ibrahim et al., 2020; Otte et al., 2020a; Walker & Bryant, 2013).

The importance of self-care (e.g. psychotherapy, meditation, relaxation techniques) (Burr et al., 2020) and access to sick leave (Shepardson et al., 2019) have been reported in the literature. Moreover, findings from a systematic review show that PSWs' access to a peer support network or a community of practice helps them better address the potential challenges concerning their wellbeing (Ibrahim et al., 2020). Gates and Akabas (2007) have identified a lack of networking opportunities and social support as one of the stressful hindrances to PSW integration in mental health organizations. Berry et al. (2011) report on a PSW's experience: "*I seem to be the only one that's working in this pure peer role and that has, on occasions, felt a bit lonely*" (p.244). Isolation can take a toll on PSWs. The theme of isolation is prevalent in the literature, and the phenomenon of isolation is particularly evident in health systems and organizations that do not have depth and breadth in policies and practices that enhance peer support. We have outlined various areas where policy makers and leaders in organizations can intervene to help create system and organizational change that values peer support work and enriches the work life of PSWs.

In sum, the focus at the micro level is on the PSWs' relationships and experiences. The literature indicates that cultivating professional, positive and trusting relationships with team members facilitates integration of PSWs in mental health teams. As our discussion indicates,

however, the onus is not only on the PSW to cultivate positive relationships, as this is difficult to undertake when one faces stigmatization, discrimination, and prejudice from other staff. This points to the importance of change management and training approaches at the organizational level to educate those in the PSWs' role set about the importance and practice of peer support (as we discussed in the meso factors section). Ensuring wellbeing and setting role boundaries with both peers and team members enables implementation of the PSW role.

DISCUSSION & CONCLUSION

This review of the literature suggests that peer support role implementation in mental health care is facilitated by enablers at three levels—macro, meso and micro. In what follows, we outline our contribution, address limitations, reflect on important themes related to PSW role implementation that were addressed or omitted from the literature, and point to implications for future research, as well as for policy and practice.

Our review contributes to the literature in various ways. The review includes empirical research using a variety of data collection/analysis methods, as well as scoping and systematic review papers on specific topics, and hence offers diverse angles from which to understand PSW role implementation. Further, while the number of studies and the approaches used in research have increased over the last few years, indicating a growing interest in an important topic, the information available is not structured or organized to provide a comprehensive view. Our review provides a comprehensive, holistic view that—to our knowledge—has not been attempted in the literature, and yet is much needed to provide integration. In this review, we have organized the findings from the literature into three levels of analysis, showing the multilevel factors that influence PSW role implementation in mental health care. In addition, we have provided a

multilevel framework outlining the interlevel influences in Table 2-2. Another contribution is to offer a multilevel framework that may be adopted and/or adapted in other research or reviews that focus on implementation of roles, programs or changes in health care.

This review, like other reviews, also has limitations. Despite our consultation and close work with a Librarian and our best efforts to be thorough, it is possible that a researcher using different terminology for the literature search might identify other articles that were not captured by our search criteria. Further, any review relies on interpretation and determination—made by the researchers—of the key themes to include in the literature synthesis (Greenhalgh et al., 2018). Other researchers may employ other themes in their review.

Implications for Future Research

Research has consistently showed that the challenges outweigh the enablers of PSW role implementation. While there is extensive evidence and research on influences at the meso and micro levels, factors at the macro level have received less attention, and are on occasion vaguely implied. We outline areas of future research that need to be pursued—most (but not all) at the system level—and consider how such research can also attend to dynamics at the meso and/or micro level.

The review showed the importance of attending to professional power dynamics at the macro level in understanding PSW role implementation. Literature on the sociology of professions indicates that professions claim professional legitimacy and autonomy to provide services due to education, credentials and licensure (Abbott, 1988; Freidson, 2001). Power dynamics have been a recognized issue at the system level as the creation of new roles threatens power and status of members of established professions (Currie et al., 2012), and policy-driven

workforce developments in highly professionalized health systems create tension by confronting the more privileged professions with newer occupations (Bourgeault & Mulvale, 2006). Research is needed to identify how the introduction of the PSW role at the system level is met by associations representing established professions, and the dynamics that lead to either collaboration or competition. In a similar vein, it is important to understand how knowledge and expertise based on lived experience can become legitimized and accepted by a system focused on knowledge based on formal education and extensive socialization. Future research can also address whether and how collaboration enacted at the system level has a trickle-down effect to the organizational level (for example, in terms of providing PSWs with similar work conditions and recognition as other professionals) and at the micro level of interactions.

In addition, in our review, we found that research from high-income countries (HICs) e.g., the US, Australia, Canada and the UK constitutes the majority of publications. A number of authors state that peer support has been applied and studied primarily in Western contexts and little is known about peer support in non-Western contexts (Fan et al., 2018; Gillard, 2019; Hall et al., 2019; Tse et al., 2017). The limited research on low-mid income countries (LMICs) and non-Western countries such as Kenya, Timor-Leste and Hong Kong (Hall et al., 2019; Tse et al., 2017; Wall et al., 2020) showed that PSW role implementation can provide culturally acceptable/consistent and affordable services (Fan et al., 2018; Puschner et al., 2019), and can be a means to engage "families and communities as active participants in health system development" (Hall et al., 2019). Often lack of resources and shortage of health professionals drive the employment of PSWs in some countries, especially in rural or remote areas. Further research is needed on LMICs and non-Western countries that uncovers existing and promising practices of peer support and helps build an evidence base (Wall et al., 2020).

This review has showed that a number of jurisdictions have regulations (e.g. requirements for embedding peer support in mental health teams) or programs (e.g. for certification) in place to enable implementation of PSW role, yet evidence is mixed regarding the effectiveness of these approaches. Research is needed on how regulations are effectively translated to practices at the meso and micro levels in such a way that helps avoid tokenism of peer support. Comparative research across jurisdictions that have had more and less success with implementation, focusing on the system level dynamics that enable and hinder role implementation would help provide more clarity.

Moreover, this review has showed that economic uncertainty at a national or jurisdictional level has not received sufficient attention in the literature, yet is likely to play an important role in influencing PSW role implementation. This is a topic that is ripe for further research. The review has also showed that system level funding for PSW employment is not strongly institutionalized in most jurisdictions. More research could elucidate the *financial return on investment* related to employment of PSWs—an area that has not received sufficient attention. Collaborations with researchers in the field of health economics can help identify approaches and measures that could be used. This should be in addition to considering the *social return* in terms of achieving recovery and wellness for people experiencing mental health problems, reduction of various forms of stigmatization and integration in the community. These and other topics we have proposed as directions for future research would benefit from data collection through interviews with policy makers to obtain their views, as one source of data among others.

In this review, there was a lack of studies on how micro level factors can influence the system level, and more specifically, for example, how individual PSWs may exert any influence on the system. It is possible that such influence requires activism by individuals, as well as the

creation of groups or social movements (e.g. the consumer movement). We did not find studies that focus on system level implementation of formal peer support originating with micro-level actors. Case studies of these events—if and where available—would be illuminating. The literature on institutional work (for example, Hampel et al., 2017; Lawrence, 2017) may provide inspiration for research that would address this issue.

The papers included in this review did not address how gender may influence implementation of the PSW role. Although demographic data were reported in some survey studies, there was no indication as to whether the gender of PSWs was a factor in their role implementation. Future research might examine if and how gender stereotypes impact PSW role implementation. Literature on community health workers, for example, has identified relative lower wages for female workers (Ved et al., 2019). How gender might influence hiring, remuneration and other practices related to integration of PSWs in health care is an important topic for future research.

The majority of the empirical papers in this review involved qualitative research and the few studies that incorporated quantitative data tended to provide descriptive statistics (e.g., Burr et al., 2020; Chinman et al., 2012; Hopkins et al., 2021; White et al., 2003). Research on implementation of PSW role in organizations would benefit from quantitative approaches that address such topics as network of relationships that develop within the organization upon implementation of the role and how this may help explain enablers or obstacles to the implementation.

A number of studies in this review reported on pilot projects for the expansion of PSW employment in mental health organizations (Franke et al., 2010; Gates et al., 2010; Gillard et

al., 2017; Shepardson et al., 2019). Future reports on pilot studies may track the progress of these projects and the lessons learned in the different stages of implementation and institutionalization. Longitudinal research would be valuable to understand what influences the sustainability of the role.

Implications for Policy & Practice

This review has implications for policy. Policies and regulations, through their trickle-down effect on meso and micro levels, can play a central role in the recognition and acceptance of the PSW role. Policies for which there are societal readiness and acceptance are easier to enact, and because the cultural values underpinning such policies are widely accepted, there is stronger likelihood that implementation of the PSW role will go beyond tokenism. Hence, policy makers can engage in discourse and education that highlight the social and economic value of peer support based on research, thus creating legitimacy for the role in an otherwise highly professionalized and hierarchical system. This also paves the way for the allocation of more resources to peer services in mental health and provides necessary funds for organizations to plan recruiting and retaining PSWs with formal contracts. Attending to more successful cases or jurisdictions would suggest opportunities for policymakers to learn about the various ways of incorporating PSWs in mental health systems.

From a practice standpoint at the organizational level, this research provides insights for informed managerial decision-making regarding the need to adopt a change management strategy that targets and consults various stakeholders. There is also the need for adoption of a comprehensive human resources management approach. This research showed that micro level factors pertaining to improving PSWs' workplace relationships, experiences and wellbeing are essential factors in the role implementation. Organizational leaders and immediate supervisors

of PSWs can apply this knowledge by modeling stigma free approaches and behaviors.

In conclusion, peer support has been underutilized in mental health systems despite evidence of its benefits and of increasing need for mental health support and care. We hope that our paper provides a solid base for future multilevel research, policy and practice related to an increasingly important topic in health care.

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This article is part of EM's doctoral thesis. EM and SC contributed to study conception and design. Data analysis and manuscript drafting were performed by EM, and were thoroughly reviewed by SC. Both authors critically revised the drafts until finalized.

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Data Availability

The papers used for this paper are the only sources of data and they can be accessed using online databases.

DECLARATIONS

Conflict of interest

The authors have no relevant financial or non-financial interests to disclose.

Ethical Approval

No ethics approval was required as this review paper involved no human participants.

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CHAPTER 3

ESSAY 2: Work-Life Boundary Management of Peer Support Workers when Engaging in Virtual Mental Health Support during the COVID-19 Pandemic: A Qualitative Case Study

ABSTRACT

Background

Mental health care needs have increased since the COVID-19 pandemic was declared. Peer support workers (PSWs) and the organizations that employ them have strived to provide services to meet increasing needs. During pandemic lockdowns in Ontario, Canada, these services moved online and were provided by PSWs from their homes. There is paucity of research that examines how providing mental health support by employees working from home influences their work-life boundaries. This research closes the gap by examining experiences of work-life boundary challenges and boundary management strategies of PSWs.

Methods

A qualitative case study approach was adopted. Interviews with PSWs who held formal, paid positions in a peer support organization were conducted. Data was analyzed thematically using both inductive and deductive approaches. Descriptive coding that closely utilized participants' words was followed by inferential coding that grouped related themes into conceptual categories informed by boundary theory. Member checking was conducted.

Results

PSWs provided accounts of work-life boundary challenges that we grouped into three categories: temporal (work schedule encroachments, continuous online presence), physical (minimal workspace segregation, co-presence of household members and pets) and task-related

(intersecting work-home activities). Strategies used by PSWs to manage the boundaries consisted of segmenting the work-life domains by creating separate timescapes, spaces and tasks; and integrating domains by allowing some permeability between the areas of work and life.

Conclusion

The findings from this study can help inform management, practices, future research and policy on health care workforce. The study highlights the need to attend to the consequences of greater work-life integration for mental health workers since their successful practice is largely dependent on maintaining self-care. Training regarding work-life boundary management is highlighted as one of the ways to approach situations where work from home is required.

Keywords: Work-life, work-home, boundary, boundary management, virtual work, roles, peer support, mental health, COVID-19 pandemic

BACKGROUND

The COVID-19 pandemic has exacerbated mental health problems globally [1]. According to the World Health Organization, national surveys show a substantial increase in the prevalence of psychological distress in populations during the pandemic [2]. People have experienced aggravated mental health problems including major depressive disorder, anxiety, stress and posttraumatic stress disorder among others [3, 4]. While there has been an increase in mental health problems, mental health care capacity has not kept up with the demand due to difficulty in rapid adaptation to virtual care, high levels of burnout and absenteeism among health care workers, and prioritization of management of outbreaks among other reasons [5,6,7,8,9].

Mental health peer support services have been a viable resource during the pandemic [10] as peer support workers and the organizations that employ them have strived to maintain services to meet the increasing needs. Peer support workers (PSWs) – not to be confused with personal support workers— "are an integral part of the mental health workforce" ([11] p. 9); they are people who have lived experience of mental health issues and recovery and can mobilize their lived experience to provide support to others who are struggling with a range of mental health difficulties [12, 13]. Peer supporters may engage in voluntary peer support or – as in the focus of this paper – hold formal, paid positions in mental health/social services organizations [14].

In a number of jurisdictions, peer support transitioned from in-person to virtual services during the COVID-19 pandemic, often spurred by lockdowns (in the US [11]; in China [15]; in Brazil [16] and in the UK [17]). PSWs have been able to provide peer support from their homes, enabled by telecommunication tools [10]. However, for any occupation, working from home can involve challenges that include digital access and literacy, lack of workspace, and navigating work and home roles that could become entangled and cause work-family conflict [18,19,20].

There is a paucity of research that examines how providing virtual mental health support services by PSWs working from home influences the PSWs' work-home boundaries. Most research that addresses PSWs' work role boundaries tends to focus on how borders are established with peers (clients), and attends to issues of distance from peers, self-disclosure and after-hours involvement [21, 22]. The blurring of work-home boundaries and its impact on PSWs' well-being has not been investigated, and neither has there been sufficient attention to how PSWs manage boundary issues. In this paper, we close these gaps by examining the experiences of PSWs who provided virtual mental health peer support from home during the COVID-19 pandemic. The purpose of the study is to examine what boundary challenges PSWs

faced and how they managed boundaries. This is an important topic because blurred boundaries between work and home domains can be a source of strain and conflict [23,24,25], and yet peer support necessitates self-care and taking time to disconnect from work [26, 27].

Understanding how blurred home-life boundaries are experienced and managed is an important topic not only as it pertains to PSWs, but also as it may apply to a variety of health care workers. This is especially the case given the push to offer health services remotely in order to improve access, and given that these services may be provided from health care workers' homes. The findings from this study can help inform management, practices, future research and policy on the health care workforce.

We conducted our study in a peer support organization operating in a large city in Ontario, Canada. We adopted a qualitative case study approach to explore in depth how PSWs experienced the work-home boundaries after the transition to virtual peer support, and how they managed the challenges they experienced. In the next section, we consider studies that have addressed the opportunities and challenges of virtual peer support, and briefly review research on home-life boundaries and boundary management.

Opportunities and Challenges of Virtual Peer Support

Research on previous infectious disease outbreaks and health system approaches to managing the consequent mental health impacts shows that supportive community-based programs (such as routine peer support, psychological art programs and psychological first aid within communities) were effective in enhancing the response capacity of mental health systems [28]. Many of these community-based services, including peer support, have been offered through telehealth using different communication methods during COVID-19 as in-person

meetings were severely restricted [29, 30]. Research conducted during the early stages of the COVID-19 restrictions documented that people in isolation enthusiastically sought virtual support to address mental health needs, showing a population interest and acceptance of this method of support service delivery [10, 30]. Systematic reviews recognize the utility of online peer support for various mental health and well-being services, for instance, internet-based peer support for parents [31] and peer support through mobile applications for distress alleviation [32] as well as different age groups including adolescents and young adults with mental health issues [33,34,35].

Despite the need for and public openness to virtual peer support, there has been limited research on the challenges to PSWs posed by virtual service delivery from home. A recent study on the impact of COVID-19 on PSWs by Adams et al [11] investigated how the pandemic affected PSWs' day-to-day work, among other topics. The findings pointed to PSWs' engaging in new job tasks such as learning about new technology, providing support remotely and facilitating online groups. PSWs who participated in the study reported high satisfaction with supervisory and organizational support and pointed to the benefits or positive impacts from the pandemic [11]. However, this study did not focus specifically on PSWs' experiences of working from home. Studies on other health care workers show that working from home introduces disruption to the boundaries between the professional and personal lives of service providers. For example, a study on social workers reported challenges associated with maintaining work-life balance and blurring of work-life boundaries [36]. Rapp et al [37] explored the "work-nonwork boundaries" of healthcare workers during the pandemic and established the connection between the violation of work-nonwork boundary and the workers' experience of burnout (exhaustion, detachment, and inefficacy). Overall, research shows that stress induced by a work-life imbalance negatively

affected efficiency and decision-making ability leading to suboptimal care and poor productivity both at home and at work [38]. Thus, the inability to maintain work-life boundaries and balance has ramifications for the quality of life, work and client service of health care workers.

Work-Home/Life Boundaries and Boundary Management.

Researchers have emphasized the distinctions between the work domain and other life domains (including the family and the home), using the term "boundaries" to talk about these distinctions (e.g. work-family or work-home boundaries) [23, 24, 39, 40]. Boundaries are created by people to simplify and classify the world around them and thus they have psychological and behavioral ramifications [39]. Boundaries "delimit the perimeter and scope of a given domain" such as a role, a home and a workplace ([40], p. 705). Roles provide specificity as to who an individual is or what the individual does in a given domain such as home or work [39]. The home role and the work role may be differentiated according to time, space and tasks, so an individual moving from one of these roles to the other typically crosses temporal, physical and task boundaries. Blurring of work-life domains has been shown to facilitate boundary crossings and enable the achievement of some goals [41, 42]. However blurred work-life boundaries can also have negative emotional impacts, compromise wellbeing and contribute to work-life conflict [41, 43, 44].

Boundary management refers to the tactics or strategies that individuals use to manage the intersection between work and non-work domains [23] Different boundary management tactics have been documented in the literature. One way to view boundary management is to consider the degree to which individuals segment or integrate domains. A review of the literature on work-family boundary management indicated that segmenting work and life roles was associated with

lower conflict and better work-life balance [23]. Perception of work-life balance is positively associated with mental health [45]. Thus, while integrating and allowing permeability between the domains can lead to positive spillovers such that one role enriches the other, integration can also lead to negative spillovers such as role conflict and drain of one's resources [24, 46].

Another way to view boundary management is to consider the type of boundary that is being managed. For example, in their empirical study of boundary management tactics, Kreiner et al [40] referred to temporal, physical, behavioral and communicative tactics. According to these authors, temporal tactics include removing oneself from work with the purpose of rest, e.g., taking a vacation. Physical tactics are related to adapting physical boundaries by establishing or removing physical borders between work and home. Behavioural tactics include using technology to facilitate boundary work, using other people and prioritizing important work and home demands. Communicative tactics include such practices as setting expectations regarding boundaries [40].

Researchers have referred to "idiosyncratic" approaches to the management of boundaries that may be adopted by individuals [39, 40]. It is also understood that there is variation in the degree of control that individuals may exert over boundaries [24]. Hence, boundary management varies by individual (e.g. according to preferences) and by situation and context (e.g. according to family obligations).

There have been empirical studies on boundaries and boundary management in different contexts, but to our knowledge, none have been conducted on the experiences of PSWs or other mental health workers during the pandemic. Hence, we ask the following research questions: What work-home boundary challenges arose for PSWs when working virtually from home

during the COVID-19 pandemic? How did PSWs manage the work-home boundary challenges? We focus specifically on the work-home boundary, and we use this term interchangeably with work-life boundaries in our findings. We focus on work-home boundaries because the context of our study was one of imposed lockdowns and stay-at-home/work-from-home mandates.

METHODS

Aim and Research Approach

The aim of this study was to examine the work-home boundary challenges PSWs experienced and their boundary management tactics. We adopted a qualitative case study research approach as it provides an in-depth understanding of people's experiences and the context surrounding these experiences [47]). The strengths of qualitative methods include the ability to pay strong attention to context, and respect and report on the experience of participants [47, 48]. Our approach allowed achieving a deep understanding of workers' experiences and management of work-home boundaries.

Setting and Context

We conducted our study with members of a peer support organization that operates in a large city in Ontario, Canada. Prior to the COVID-19 pandemic, the organization provided almost all its services in person in various programs, reaching a large peer (client) base. At the time of the study, the organization employed twenty-one paid PSWs, some of whom held managerial positions in the organization. The study was conducted during the earlier days of the pandemic when work-from-home mandates had been enacted in Ontario. We selected this case because the organization transitioned all its services to virtual platforms in a short period of time in order to meet the increasing demand for peer support at a time of lockdowns and isolation. This case

allowed us to capture the richness and complexity of the emerging work-home boundary issues during the pandemic through the lens of PSWs' experiences. The case is also illustrative of work-life challenges that individuals encounter during an enforced and very quick transition to work from home.

Data Collection

Semi-structured one-on-one interviews were conducted during the pandemic (February to June 2021) with paid PSWs, some of whom also held managerial positions in the organization. All paid PSWs of the organization were invited to participate in the study. Thirteen individuals (including four PSWs who held managerial positions) agreed to participate. This constituted 62% of paid members of the organization. Participants included 11 women and two men, most of whom held full-time positions. All participants were asked to describe their work roles prior to and post the work-from-home mandate. They were asked to describe their lived experiences of work-life boundary issues (opportunities and challenges) that occurred as they transitioned to providing virtual peer support. Further questions were asked about strategies they used to manage the work-home boundaries. Participants were encouraged to provide examples throughout. Interviews, which lasted between 60 and 90 minutes, were transcribed verbatim and anonymized.

Data Analysis

N-Vivo software was used to facilitate data coding and retrieval. The interviews were analyzed thematically (as outlined by Miles et al [47] and Hennink et al [49]) using both an inductive approach that captures the perspective of the participants and a deductive approach that is informed by theoretical notions. The constant comparison method was used to derive and refine themes across interviews. In the first stage of the analysis, descriptive coding that closely

utilizes participants' words was used [47]. This was followed by inferential (second-cycle) coding which allows the joining of related themes into a smaller set of categories that are more abstract [47]. At this stage we referred to the literature and used conceptual notions derived from boundary theory to aggregate the findings.

Confirming Findings: Quality, Credibility and Trustworthiness

In November 2022, we conducted "member checking" [47] to collect feedback from participants and to confirm that our interpretations matched their experiences. This tactic is important in qualitative research on lived experiences, since as Miles et al [47] point out, participants in the setting are "bound to know more than the researcher ever will about the realities under investigation [and] can act as judges, evaluating the major findings of a study" ([47] p. 303). To ensure the credibility of our findings, we met with and presented our results to a senior manager and three PSW representatives of various services provided by the organization (e.g. hospital peer support, recreational peer support), and asked them for their feedback. We also sent all employee members of the organization the full draft of our paper and invited them to provide feedback on the paper. In total, we obtained feedback from seven organizational members. The feedback we received indicated that our results reflected the experiences of PSWs, but also offered refinements to our analysis. With respect to feedback on the Results, we were told that *"the results are spot on"* and *"the study really captured what I have been experiencing as a peer supporter working virtually"* but that some of the challenges we reported did not apply to a few of the PSWs who had had previous experience working virtually in a different context, or who had become proficient in setting boundaries over their many years of experience doing peer support. Hence, we included these topics in our Results section below. Participants also emphasized the importance of highlighting the sudden and radical nature of the change in work

arrangement during the pandemic lockdown, which partly explains the many challenges we reported. We thus included this topic in the Discussion section.

RESULTS

We report our findings in three sections. In the first section, we focus on PSWs' experiences of work-home boundary challenges, and in the second section, we elaborate on the boundary management tactics utilized by the PSWs. Table 3-1 summarizes the boundary challenges and boundary management tactics.

Table 3-1.

Work-home boundary challenges and management tactics

Work-home Boundary Challenges	**Temporal Boundaries**	**Work schedule encroachments**
		Continuous online presence
	Physical Boundaries	Minimal workspace segregation
		Co-presence of household members and pets
	Task Boundaries	Intersecting work-home activities and tasks
Work-home Boundary Management Tactics	**Segmenting domains: closing borders and separating work from home:**	Negotiating and finding workarounds
	Temporal tactics	Actively limiting time spent on work activities
	Segmenting domains: closing borders and separating work from home:	Designating separate physical spaces for work and non-work activities
	Physical tactics	Using physical markings and objects to symbolically separate the domains
	Integrating domains:	Taking work-related calls during personal time
	Opening borders and allowing some boundary permeability	Addressing home-related topics in the context of work activities

It is worth noting that PSWs told us about opportunities that arose due to working from home, such as the ability to save time and money by not commuting to work every day, engaging in self-care such as cooking and eating lunch at home, and spending time with loved ones during work breaks. However, their accounts concentrated mostly on the challenges, and this is the focus of the paper. Attention to the challenges allows us to understand how PSWs exercised agency and insight in overcoming difficulties through boundary management, which we report in the second subsection. It also allows consideration of policies and organizational practices that can help mitigate the challenges (addressed in the Discussion).

Experiences of Work-Home Boundary Challenges

Participants pointed to major challenges that we grouped into three categories: temporal work-home boundary challenges, physical work-home boundary challenges, and task boundary challenges. Temporal challenges address difficulties associated with intermingling work and non-work schedules, as well as what participants experienced as continuous online presence for work purposes, even during non-work hours. Physical challenges refer to difficulties separating home space/objects, and household members from work situations. Task challenges manifested in the intersection of home activities with work activities. We address each of these challenges next.

Temporal Work-home Boundary Challenges

Temporal work-life boundary challenges consist of work schedule encroachments and continuous online presence.

Work schedule encroachments

Early in the pandemic, worksite (office, hospital) peer support services were cancelled, and all the services shifted to online and phone support. Thus, the work schedule of the PSWs had to

change to adapt to the new way of providing services in virtual space. During the pandemic, PSWs experienced constant modifications to their work schedules because of uncertainties associated with unforeseeable rules relating to COVID-19 restrictions and because achieving a better understanding of peer needs led to changes in programs offered. These changes caused less predictability and less ability to plan for non-work activities:

> *"It's been very unstable, we're constantly changing to try to meet whatever the government is doing and what the peers want: updating programming, finding new ways to do things. I had a very predictable schedule…, but now… we're moving things around… which makes things difficult."*

The work schedule challenges were related not only to instability and unpredictability but also to difficulty segmenting and sequencing work and life activities. Before the pandemic, PSWs had clear distinctions between work and non-work hours, and most typically had one block of several hours a day dedicated to working, and these timescapes allowed PSWs to segment work activities from other life activities. However, during the pandemic, the peer support tasks were distributed in split blocks of time with non-work intervals throughout the day:

> *"I would drop my kids off at school, I got to work, and would park my car a little bit away and walk to work, so I have a little time for myself… and then [at the end of the workday] the whole thing in reverse, walk back to my car... Whereas at home, I may have a group in the afternoon on zoom and then another group later in the day... It's all disjointed and, in between, I don't have work to do, but I don't feel like I'm really relaxed."*

In addition to work scheduling being disjointed, PSWs reported an increase in work owing to increased need among peers and coworkers. A PSW stated: *"My workload is so heavy that I've run a to-do list that's several pages long every day. By the time I get through that, I have to write another one, so it's like the workload never ends."* PSWs faced difficult situations when they had to set boundaries: *"I sometimes don't understand what's an unreasonable ask… I'm trying to suss out needs and that for me is probably one of my biggest weaknesses. I just sometimes don't know how to set the right boundaries".* People's expectations about PSWs' responsiveness and accessibility were challenging to manage. A PSW explained that:

> *"Boundaries around time are really interesting because some people [peers] expect you to be available Monday to Friday 9 to 5, no questions asked. Some people are expecting you to be available before or after that… They'll send you an email saying 'this is what I need' – and it's really hard to set boundaries."*

Moreover, some PSWs' sense of responsibility and solidarity with peers or coworkers overrode their need to set boundaries. They felt compelled to respond to requests outside of their work hours even at the expense of their well-being. A PSW spoke about feeling "*a sense of responsibility"* towards coworkers given that there was *"a lot of burnout and if someone needs me, I want to be there for them."* Another PSW stated:

> *"I have a really hard time telling people no if they say, 'I need to speak with you'… I'm still really trying to navigate the best way to have firm boundaries that are respectful of others... I'm always worried that things are gonna get dropped, that someone's gonna get forgotten about or some piece is not gonna be picked up."*

Before the pandemic, PSWs were able to transition from work to non-work and vice versa

due to a time lag. During the pandemic, the lack of temporal separation between work and non-work, and the increased workload and expectations led to the blurring of work and non-work domains. What used to be separate timescapes with clear boundaries were now intertwined, with work often encroaching on non-work time.

Continuous online presence

When peer support services transitioned to a virtual space, several means of communication and connection became available, however, conventions of when and how these means could be accessed were not clear. Ease of access to work emails, chats, or phone calls furthered working longer hours. While before the pandemic the PSWs could check emails, they were now more tempted to answer an email when they were not on formal work time. Various reasons for increased engagement with work were identified. PSWs reported spending more time in front of a screen compared to pre-pandemic times. Being online was not necessarily for work reasons; nevertheless, many felt that by being online they were drawn to engaging in virtual peer support work. Finally, during the pandemic, PSWs connected more with social media and other resources online to obtain COVID-19 news.

> *"I think COVID is providing a platform where we have our laptops and phones open all the time because we want to know what's happening outside our house. Especially when there's a lockdown, it's like, we're not able to go here, go there. So we're maybe looking for friends, what are they doing? What are other communities doing? So there's more of that inclination of seeing what's happening around the world.*

During this time, work-related emails were often present and open on screens and could hold PSWs engaged with work beyond work hours. Several participants indicated that they engaged in

virtual non-work activities before the pandemic. However, during the pandemic, those non-work activities involved online presence where work activities also took place:

> *"I play a lot of video games, but my work email is open now a lot of the time, so even if I'm off work, if I've forgotten to close my email, I'm looking at what's going on at work when I'm usually pretty good in person at making sure that doesn't happen. I have pretty firm boundaries that I don't do work when I'm not working. I've lost a lot of that since we've been working from home because it always feels like there's something going on."*

For some PSWs, it would take effort to refrain from reading and replying to work-related messages during non-work hours when hearing an email notification sound. A PSW mentioned, "*it [the message] is constantly at the back of my mind"* commanding attention even during personal time. Another PSW spoke of difficulty "turn[ing] off the work mind", and a third declared: "…*if I hear an email coming in at nine o'clock at night, I'm going to look at it and I'm going to maybe respond, or it will be on my mind. So my time management with that can be a little tricky.*" In some situations, PSW felt a sense of responsibility to manage what was occurring online during off-work hours, especially because the pandemic led to the heightened use of online platforms that posed additional challenges:

> *"We have that Facebook group, virtual drop-in group. So people can go on and make comments any time of the day or night. So when people were being inappropriate… here you are at 8:30 at night in your PJs. And you're having to deal with the situation because you can't leave it till the next morning, it's on Facebook."*

Thus, work-schedule encroachments and continuous online presence gave rise to heightened temporal boundary challenges.

Physical Work-home Boundary Challenges

As PSWs transitioned to working from home, the coexistence of work and home life led to the blurring of physical boundaries that previously delineated these domains. This section delves into two primary aspects: minimal segregation between the workspace and the home space, and the presence of household members and pets in what became the workspace during the pandemic.

Minimal workspace segregation

The early stages of the transition to working from home were described as "chaotic" and the PSWs found themselves in a space that was at once work and home. The co-presence of work and home life led to the blurring of the physical boundaries that were used to separate these domains. This was particularly challenging for PSWs who had limited discretionary space at home that they could customize as a separate workstation. A PSW who did not have an office set-up at home spoke about the challenge of "*having all work in the home": "If I've had a stressful day at work, that lingers with me and I'm like 'Ugh there's my work piled up there and I don't want to think about it.'"* Another indicated that having little space at home where work and sleep occur in one place leads to blurred physical boundaries. Before the pandemic, PSWs worked at hospitals or their offices, and they would leave behind their notebooks, documents, and work laptops at work sites. However, during the pandemic, these work-related objects were transferred to their home space (work-to-home transfer). Work objects now physically inhabited the home space, encroaching on home life. A PSW stated:

> "*I set up [a workstation] in my [leisure] room, but I found I couldn't divide the space. I would go in there and it was work, and before COVID it was my leisure space. I stopped really using it as that because it just felt too 'work'."*

There were home objects that now had to be used for work, such as desks, electronic equipment and others (home-to-work transfer), and this tended to be disruptive. A PSW stated: "*It's chaotic, like 'Okay now we're going to eat dinner, clear everything' to 'Oh, I'm doing work now, bring it back'!"* Hence for many participants, working from home was disruptive to home life. Some PSWs took longer to adjust to the change, indicating that it was challenging to make a mental shift from being at work to being at home given the permeable boundaries:

> *"I couldn't figure out how to make it work, how to be organized, and how to keep it separate. And it didn't even occur to me that I should make a separate workspace. I just was not in a good space. I was working at the dining room table or on the couch, wherever I could just take my laptop… And I would make notes from staff meetings and then I would lose the notes. I just could not seem to mentally make that shift."*

Presence of family members and pets

Several PSWs commented on the co-presence of individuals from different domains in the space where work activities were undertaken. While on virtual (Zoom) meetings with peers or co-workers, household members or pets could be present in the room. A PSW stated: *"I was working…but then life was going on around me and I found that very distracting and frustrating*", referring to the presence and activities of household members. Another PSW spoke about the experience of "immediacy" in sensing a household member's physical presence when performing PSW work:

"At first it was definitely really hard for me to focus… If I'm physically at work, I'm very focused on what I'm doing because I'm 'at work'... There are so many distractions at home like that immediacy in knowing someone physically, the feeling of them being in the room, which I can't express very well."

The quote above expresses discomfort in experiencing in the same space the presence of two domains – work and home – that until then had been separated physically. Individuals were not the only source of distractions. Pets could also command attention and pose challenges.

"I have pets, so there's been a lot of me being like: 'Just one moment I need to go chase my dog" or 'my dog is barking at something, and I need to check what the freaking out is about.' … where that's not something I've ever had to deal with before in a workspace. It also applies when I'm on the phone because my dog barks, so people will be like 'Hey what's your dog's name, how long have you had your dog?'… It's more the psychological thing, like my own feelings about my space."

As the above indicates, the movement of work to the home space posed challenges in terms of PSWs being constantly reminded of the presence of work through work objects, inability to physically separate the two domains when one inhabited a small space, disruptions to home life because of use of home objects for work, and having to deal with the presence of household members and pets during work activities.

Task Boundary Challenges

Work and home tasks and activities became intertwined, creating challenges for PSWs as we show below.

Intersecting work-home tasks and activities

In the above sections, we discussed the challenges associated with temporal and physical boundary permeability. There are implicit references in those sections to the challenges associated with enacting both work and home roles in the same space and same time. In this section, we further elaborate on the permeability of work and home roles that had been mostly segmented before the pandemic, giving attention to the experience of the intersection of the home and work tasks and activities for many PSWs. In the following PSW quote, the notion of role is captured by the notion of hat:

> *"We talk about hats a lot in peer support, like I have my peer supporter hat, I'm wearing my friend hat, and I'll be interchanging them. And that is a lot harder here. It feels like I'm home Jane, but at home Jane is taking care of her animals, at the same time peer support Jane is trying to take care of a group! Then it gets a little bit tangled."*

PSWs who had younger children or children with special needs spoke at length about the experience of wearing different hats at the same time. With the pandemic lockdowns, schools and other facilities shut down. Schools moved classes online, and this often required that parents be available for their children's classes online. This created a major burden on PSWs who needed to navigate the needs of their children and the work requirements:

> *"It's not like I could go separate myself. My kid is young, she's 6, and she needed me around to help her with her schoolwork. She couldn't join her class online because it's not for where she's at, so that meant me homeschooling while she was here. That was a big challenge."*

The peer support work role may require difficult emotional labour, and PSWs deal with the

difficulties in various ways. It is well known that PSWs need to exercise self-care and that this takes different forms for different individuals (13, 27). Intersecting home and work roles made it difficult for some PSWs to recover from emotional and complicated peer support sessions. A PSW told us about how exercising different roles simultaneously was challenging and left some mental health needs unsatisfied:

> *"When school was closed, my child was at home. Normally when I would go to work, my child is at school, I'm at work and for those six hours, I'm not a parent, I'm doing peer support… If I had a difficult group, maybe something I felt was difficult or maybe a difficult phone call, I can't just cry in the other room [at home] because there's homework or virtual school. For me, that's been really challenging because I don't feel like I have a separation between my work and my personal life, which I feel that I need for my own mental health."*

As the above indicates, PSWs experienced challenges associated with an overlap of work and home tasks. In the next section, we consider PSWs' boundary management tactics.

Work-home Boundary Management

The above findings show that the early stage of the pandemic was a new experience for PSWs and navigating working from home posed many challenges. As the pandemic progressed, and work from home persisted, PSWs implemented tactics to protect their personal and work roles by identifying their boundaries and managing them. These boundary management tactics were individualized in the sense that each PSW had specific contingencies they needed to take into consideration in managing boundaries (such as the availability of space in the home, and the timing of other family members' needs). The process by which the PSWs developed boundary

management tactics was gradual and somewhat experimental. It took shape as PSWs gained experience and learned about solutions that worked for them:

> *[At first,] I couldn't figure out how to make it work,… how to keep it separate…. And one day it occurred to me that I could make an office. … I saw somebody's home office in one of our staff meetings…. I have a large master bedroom,… so I thought, oh, I'll just put a little desk in there. And so half my room is an office, and half is my bed and whatever. And I really try to keep them separate." learn*

> *"I share my house with my [partner], and they also have virtual work to do… We had to buy another computer because we were trying to organize when someone was on the computer, and it wasn't gonna work. We also shared an office, and we very immediately realized that it wasn't gonna be possible… There was adapting in our home."*

These quotes show that PSWs had to adapt to virtual work from home and implement temporal and physical changes that allowed them to navigate the work and home boundaries, and that doing so was not an easy endeavour. Yet they found tactics that allowed them to manage boundaries. Most tactics involved segmentation (or separation) of the domains as in the above two quotes, but not all tactics did. In the remainder of this section, we elaborate on the work-home boundary management strategies that PSWs implemented. We categorized them into *segmenting* tactics involving separating the domains and *integrating* tactics involving allowing some permeability and integration of the domains. Each of these boundary management strategies is further broken into tactics as shown in Table 3-1. Note that these tactics were not mutually exclusive, as it was possible for an individual to separate time and space at once, for

example, or to use negotiation not only to manage temporal boundary challenges but also physical challenges. We separate them here to facilitate the presentation.

Segmenting work and non-work time

PSWs engaged in negotiations with people at work and/or home to set work-life temporal distinctions. Some PSWs had to come to agreements with managers on work schedules that took into account other important contingencies in their lives. Increased workload during the pandemic, family obligations and the need for self-care time were some of the reasons for negotiations around work schedules. A common impetus for negotiations was the needs of household members which interfered with work hours during the pandemic, especially given the lockdowns. Adjusting the work schedules became necessary for PSWs who were parents of young children needing to be home-schooled or parents needing to be present with their children during virtual classes.

> *"I went to my manager and said, 'I'm going to be no good to any of you and I'm not gonna be able to carry my weight if I don't reduce my workload…'. They [the managers] honoured that and I went down to [x] hours a week, and I helped out when I could until I felt better, basically until [my child's] school ended. That definitely helped because it gave me time to do some self-care. It gave me time to do those pieces because I couldn't control these other things, and I'm not gonna go dump my [child] somewhere, or let [their] needs not to be met."*

> *"[My child] couldn't join the class online, so that meant me homeschooling. That was a big challenge… I worked my hours when [my child] was either in bed or at [other*

family member's] …. Work was flexible and adjusted to what I needed because otherwise I just couldn't work.

Some PSWs set out actively to limit time spent on work activities, exercising autonomy in doing so, and setting their own rules: *"I've been really trying to stick to my time parameters. I work morning to afternoon…. Outside of this…I'm not working. Because that would be honoured in person."*

PSWs also communicated with family members, attempting to create a time to do work from home – time that would be protected from other home activities. They negotiated with partners attempting to find workarounds for each other's activities:

"I give my [partner] my schedule, 'at these times during the day I am not available..., you have to do whatever needs to be done when that happens… And my partner does the same thing with me, it's a give and take. So I'm constantly protecting my personal life and constantly protecting my professional life."

"We actually have home meetings to outline things like 'when do you need our landline and is it okay?' We actually have calendars, and we figure out when we're in, or 'if you want to vacuum, you have to bring that up at the meeting – like, I'm gonna vacuum today, I'm gonna be making a lot of noise, when's the best time to do that?' That sounds crazy, but that's what it took for us to figure it out."

These temporal segmentation practices allowed PSWs to dedicate some distinct time slots to work and others to non-work activities in such a way that life contingencies that changed dramatically during the pandemic could be attended to.

Segmenting work and non-work physical space at home

Separation of workspace from non-work space at home involved reorganizing rooms, furniture, equipment and objects, some of which had utility, for example, for home and others were symbolic of work and their presence in the non-work environment evoked work situations. The extent to which physical separation of domains could be created depended on the availability of space and resources: *"I was able to set up a spare bedroom as my office space"* and *"we got to take any of the equipment from offices home that we needed"*. When space resources were more limited, PSWs created physical segmentation through other means that were often more temporary:

> *"We don't have an extra room that we can make into an office. The computer is in the main part of my house, so if I'm doing peer support work, I put the virtual background…. If my kids are home, I don't do the peer group work on the main computer. I have to go to the basement or to my bedroom with the laptop where I can close the door so that it's confidential."*

The tactics PSWs used were intended to carve out space that reduced boundary permeability. There was a strong effort to prevent home-to-work spillover, and to protect one's private space:

> *"When I'm working with peers, I try to always sit at my dining room table and that's my peer space… I've been considering my dining room table my office space, so when I'm with peers I try very much to stay in that space. I'm trying to keep this [other] part of my house private."*

For most PSWs, the work and non-workspace areas were signified by different furniture, equipment and other objects that PSWs used for the accomplishment of work tasks. For PSWs

with personal interests requiring the use of computers or laptops (e.g. video games), the use of different items of equipment enabled the PSWs to prevent their peer support work from blending with their other interests or activities: *"I made a decision to get this other laptop so that when I'm working, I open the work laptop and that seems to be really helping. So then when I close it, I'm done."* Other objects were also used to create segmentation, sometimes symbolically because the objects would have utility in both the work and home spaces, yet designating a specific object for one space (e.g. work) only signalled the entry of the PSW to that (work) space:

> *"What I do is I have a cup from work, a mug, and I only use it when I'm working."*
>
> *"I really like sticky notes, but I only use the green ones for work and the other ones are for my other stuff."*

PSWs also used physical boundary markings (objects, open or closed doors) as a way to signal to other household members such as partners and children whether the members were welcome in the PSW workspace. Some PSWs indicated that if their door was shut, the message to others in the household was that they were expected not to enter the room:

> *"We set a rule [with family], when the door is closed, don't come in. If the door is open the whole way, hello, anytime you want, if the door is halfway closed, then I'm working, but if you need to, then you can come in."*

The physical borders that PSWs created allowed them to segment the work and non-work domains. This segmentation allowed them to detach from work when they exited the workspace or distanced themselves from work objects. Leaving the work-related physical markings behind allowed the psychological transition to the non-work space.

Integrating domains partially - opening boundaries

Most of the tactics that PSWs told us about were those intended to create segmentation and separation of the work and home domains, and we have addressed those in the previous two sections. However, there were a few instances and tactics of partially integrating domains and allowing some boundary permeability. A few PSWs told us that they allowed some boundary permeability and blurring of the domains either because they had previous experiences setting boundaries, felt the need to help others or were personally comfortable with opening aspects of personal life (e.g. pets) to others. The following quote is from a PSW who indicated that they may receive calls during personal time, but that they would tell the caller how much time is available for the call, at the end of which the PSW terminates the call:

> *"My boundaries are very wide and liberal…I've been doing the work that I do for [many] years, so setting boundaries with people comes a little easier for me. I tell people they can call me "whenever", however, I also tell them that I may not pick up the phone. If I do pick up the phone, then I let people know that I only have "x minutes" and when "x" is done then I thank them and am able to end the call."*

On the subject of opening temporal boundaries and taking work calls during personal time, another PSW mentioned a sense of responsibility towards colleagues, especially in the context of the pandemic and the difficulties that it had created for many coworkers:

> *"I don't have [many family responsibilities], so I've put that pressure on myself knowing that a lot of my coworkers have school-aged children, and that, in particular, challenges during COVID have been extremely stressful. I've been taking on a lot of stuff… It's also just my general boundaries with myself, I've kind of loosened them a little*

bit. And that's not been super healthy for me either, but I'm still doing it… I'm like, we need to support our staff to maintain their wellness… (The staff) know if there's something they can't deal with or they're struggling with…, I'll pick up my phone if I'm available."

Some PSWs also stated that they had allowed some degree of flexibility and willingness to accept spillover from home to work when it had a positive impact on their work and no negative impact on their personal lives. One topic that some PSWs did not mind sharing with others in work situations was their pets:

"I have my dog and he barks, so people [on the phone] will be like "hey what's your dog's name, how long have you had your dog?" That kind of stuff is okay because I'm used to going into it. People often see pictures of my dog at work, because my dog is very cute so I'll show pictures to make people happy, it works pretty well. So that's kind of all stuff I'm used to talking about anyways."

The quotes in this section show that there were instances when PSWs either were comfortable with some boundary permeability or felt a sense of responsibility to co-workers to be available to them during personal time. However, as the second quote in this section shows, allowing boundary permeability could alleviate some work challenges, but create other challenges for the PSW.

The quotes in this and previous sections also point to several factors that influenced the boundary tactics that PSWs utilized. We had indicated earlier that these tactics tend to be idiosyncratic to individuals and depend on a number of contingencies. Although the influences were not the subject of this study, the data we collected provided indication of some of these

influences. These included the personal preferences of the individuals (e.g. *"my boundaries are wide and liberal"*), the non-work obligations and roles occupied by the individuals such as being a parent, a partner (e.g. "*I'm not gonna go dump my [child] somewhere"*), the resources provided by the organization (e.g. "*we got to take any of the equipment from offices home that we needed"*), and the understanding of the managers of the individual difficulties that PSWs were facing and the support managers provided (e.g. *"[The managers] honoured that and I went down to [x] hours a week").*

In the next section, we discuss our findings in light of the literature.

DISCUSSION

Boundary Challenges and Management

The COVID-19 pandemic had an unprecedented impact on the work-life boundaries of health workers who had to quickly pivot to providing services remotely. In this study, we focused on PSWs whose roles had to transition rapidly from in-person to virtual service provision from home. Research shows that role change tends to occur over an extended period of time during which various adjustments are made allowing health care workers to adapt to the change [50, 51]. However, the pandemic and mandated lockdowns required immediate role changes, giving PSWs limited time to adjust. The sudden change created uncertainty and confusion [52], prompting the workers to navigate a chaotic situation fraught with temporal, physical and task boundary challenges.

Our findings reveal some similarities with those of other studies. In a scoping review, Chemali et al [53] indicate that most research shows that the effects of the pandemic on health care workers were negative. The studies they reviewed document strain, increased workload,

disrupted work-life boundaries, and work-life imbalance (e.g. [7, 54]). Similar findings were reported in an empirical study by Rapp et al [37]. However, these studies have tended to focus on physicians and nurses, with limited attention to individuals from other occupations. A study that focused on the main themes of discussion that came up among social workers participating in mutual support groups during the pandemic reported that one of these themes related to challenges associated with balancing time for professional and personal life [36]. Social workers reported challenges in maintaining a healthy work–life balance and pointed to stress and difficulty maintaining professional–personal life boundaries, especially during the first two months of the pandemic. Increasing levels of stress and exhaustion were due to removing the rigidity related to particular work settings and hours. Together, these studies focus on the effects of the pandemic more generally, and not specifically on types of boundaries in the case of work-from-home situations.

Our study of PSWs showed that some participants experienced work-life temporal boundary challenges associated with work schedule encroachments and continuous online presence. Extended work availability is shown to adversely impact employees' overall well-being and to be associated with emotional exhaustion [55]. We also found that integration of work and home domains can create physical boundary challenges, a commonly identified boundary issue in remote work/work-from-home literature [56]. In our study, the physical boundary challenges manifested as limited workspace segregation from home space, and co-presence of household members in the workspace. Working from home also created challenges for PSWs in terms of managing task boundaries. PSWs' work, by definition, involves providing support, and this becomes ingrained in the role and identity of the workers. We found that PSWs juggled the tasks associated with meeting the needs of peers (clients), co-workers who also needed support, and

family members who needed attention. This created dilemmas regarding how participants needed to direct their support tasks, energy and resources.

Our study also revealed the PSWs to be resourceful and capable of managing the challenges. Despite an initial period of difficulty when the changes were first enacted, PSWs identified their boundaries and sought tactics to actively manage them. The tactics involved segmentation or integration of work-life domains. Some of these strategies have been documented in studies of other occupations (e.g. Kreiner et al [40]), but as far as we know, no study has provided an in-depth view of PSWs' or mental health workers' work-home boundary management tactics when engaging in virtual work.

Our findings showed that some PSWs strategically sought a degree of boundary integration that allowed controlled permeation between work and home domains. Thus, workers took calls out of work hours and selectively addressed home-related topics (e.g. pets) in the context of work activities. However, integration was not the only way work-life boundaries were managed, and in fact, it was sought less frequently than segmentation of work and home domains. Segmentation implies closing the boundaries, which protects a domain from incursions by other domains [57]. Thus, we saw PSWs negotiating with others and finding workarounds, actively limiting time spent on work activities, designating separate physical spaces for work and non-work activities, and using physical markings and objects to symbolically separate the domains. Research shows that physical and mental separation from work enables individuals to disengage and recover from work-related responsibilities [44].

Previous research acknowledges variations in tactics that individuals seek and considers idiosyncrasies and preferences in the degree of integration of work and nonwork roles [40, 58].

The role of an employee as an active agent in the construction of boundaries has been highlighted in the work-home/life literature [24, 40]. In our study, PSWs' boundary management tactics depended on various factors such as their personal preferences, the support they received from managers, their life commitments, and the physical space that was available to them. Not everyone chose the same degree of boundary permeability, implying that how work-life balance is achieved varies by individuals. In a scoping review of virtual work from home during the pandemic, Elbaz et al ([59], p.1) identified "heterogenous findings … with regard to work–life balance and psychological health" and the inconsistencies appeared to depend on the frequency of telework, presence of children in the home, and individual boundary management strategies among other factors.

Strengths, Implications, Limitations and Future Research

Our study contributes to the literature by advancing the understanding of PSWs' work-life boundary challenges and boundary management tactics in the context of work-from-home. This is an important topic given a) increasing needs for mental health services and support and b) expectations that virtual work will become more common in future years, and that in many cases, this work may be performed in employees' homes. Work-life boundary challenges and management are critical matters for PSWs because work in the area of peer support entails interacting with people struggling with or recovering from mental illness, and PSWs themselves have had lived experience of mental health challenges that could be triggered during peer support work [60]. This study contributes to the understanding of mental health workforce challenges and potential solutions associated with work-life boundaries.

Our study contributes to practice by informing mental health workers about the strategies they can use to manage work-life boundaries. It also contributes by highlighting important

considerations for human resource management decisions and policies. These policies could reflect flexible and more employee-oriented arrangements when a transition to work from home is required. Organizations can promote employee participation in decision-making processes that affect their work-life boundaries. Instituting flexible and variable work arrangements that take into consideration diversity of needs among employees can go a long way, especially in a context where turnover has been extensive in health workforce. Providing training related to the management of work-life boundaries such as mindfulness and learning to work "smarter" through time management [61, 62] can also be beneficial.

Our study has limitations. We collected our primary data in earlier stages of the pandemic, and as our post-lockdown material indicates, participants' challenges and boundary management tactics may change as they became more experienced with virtual work from home. Future longitudinal research can be conducted to capture how boundary challenges and boundary management strategies change with time. A longitudinal study would also be able to capture the challenges and opportunities of a reverse shift to in-person service provision. Further, given that this is a qualitative study based on data from participants in one organization, the results cannot be generalized widely. However, we have provided information on the context (unexpected, mandated and rapid changes) and deep descriptions of the PSWs' living conditions and experiences that would allow transferability of the findings to other similar contexts [47]. In addition, we pointed out that the majority of the PSWs who participated in the study identified as female. The role of gender in the navigation of work and nonwork role reconfiguration was not addressed in our study. Other research has found that gender dynamics can impact the experience of work-life boundaries and balance [23, 57]. Future research is needed on gendered experiences

of work-home boundaries of mental health workers and on their boundary management strategies [63].

CONCLUSION

This study shows that the sudden transition to work-from-home during the COVID-19 pandemic has had a considerable impact on PSWs' work-life boundaries. PSWs' experiences consisted mostly of challenges associated with temporal, physical and task boundaries. PSWs demonstrated resourcefulness and adaptability to work-from-home mandates by segmenting and integrating domains. We strongly urge attention to the consequences of greater work-life integration for PSWs as well as other mental health workers since their successful practice is largely dependent on maintaining self-care.

List of Abbreviations

PSW: Peer Support Worker

UK: United Kingdom

US: United States

DECLARATIONS

Ethics approval and consent to participate

This research involving human participants was granted ethical approval through the Research Ethics Board (REB) of the University of Ottawa (Reference number S-11-20-6226). We followed both ethical and cultural conventions and guidelines relating to peer support based on consultations with our community partner. All participants in the study were given oral and written information about the project, and they provided informed consent. In the consent form, we provided resources for mental health support in case of need. In addition, the participants

were informed of the possibility of withdrawal from the study. We confirm that all methods were carried out in accordance with relevant guidelines and regulations.

Consent for publication

Not applicable.

Availability of data and materials

The dataset used in this research is not publicly available as set out by the research ethics approval from the University of Ottawa and the consent forms signed by the participants. Further information is available from the corresponding author upon request.

Competing interests

The authors have no relevant financial or non-financial interests to disclose.

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Authors' contributions

This article is part of EM's doctoral thesis. EM and SC contributed to the study conception and design. Data collection was done in collaboration, and analysis and manuscript drafting were performed by EM, and were thoroughly reviewed by SC. Both authors critically revised the drafts until finalized.

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CHAPTER 4

ESSAY 3: Transcending Access and Technological Boundaries and Maintaining a Sense of Community in a Virtual Space: The Case of Mental Health Peer Support

ABSTRACT

Background

This qualitative study explores the experiences of peer support workers (PSWs) and service users (or peers) during transition from in-person to virtual mental health services. During and following the COVID-19 pandemic, the need for accessible and community-based mental health support has become increasingly important. This research aims to understand how technological factors act as bridges and boundaries to mental health peer support services, and whether and how a sense of community can be built or maintained among PSWs and peers in a virtual space when connections are mediated by technology. This research fills a gap in the literature by incorporating the perspectives of service users and underscores the potential of virtual peer support beyond pandemic conditions.

Methods

Data collection was conducted from a community organization that offers mental health peer support services. Semi-structured interviews were conducted with 13 employees and 27 service users. Thematic analysis was employed to identify key themes and synthesize a comprehensive understanding.

Results

The findings highlight the mental health peer support needs that were met through virtual services, the manifestation of technology-based boundaries and the steps taken to remove some of these boundaries, and the strategies employed by the organization and its members to establish and maintain a sense of community in a virtual environment marked by physical distancing and technology-mediated interrelations.

Conclusions

The study contributes to the ongoing efforts to enhance community mental health services and support in the virtual realm. It shows the importance of virtual peer support in situations where in-person support is not accessible. A hybrid model combining virtual and in-person mental health support services is recommended for better accessibility to mental health support services. Moreover, the importance of organizational support and equitable resource allocation to overcome service boundaries are discussed.

Keywords: Mental health, Peer support, Virtual services, Technology boundaries, Access boundaries, COVID-19, Sense of community, Qualitative research

BACKGROUND

There is growing awareness around the world of the need to improve mental health services, yet the response to the need has been constrained (World Health Organization, 2021). The World Health Organization (WHO) has pointed to the urgent need to invest in community-based mental health services that prioritize a person-centred, recovery approach. Among these services, the WHO highlights the importance of peer support (WHO, 2021). Formal mental health peer support refers to emotional and social support (Mental Health Commission of Canada, https://mentalhealthcommission.ca/what-we-do/access/peer-support/) provided by an individual referred to as peer support worker (PSW). A mental health PSW is a person who has lived experience of mental health issues, has paid employment in a mental health support or services organization – often after receiving training – and offers intentional support to clients with mental health challenges through empathetic understanding and encouragement of self-determined recovery (Cyr et al., 2016; Mirbahaeddin & Chreim, 2022). Peer support can promote empowerment and self-efficacy, help enhance coping skills and strategies, and contribute to overall quality of life and emotional well-being (Burke et al., 2019; Ziegler et al., 2022; Otte et al., 2020). Peer support has been particularly helpful in circumstances where traditional professional mental health services might not fully address the needs of individuals or are not easily accessible (Kourgiantakis et al., 2023; Mirbahaeddin & Chreim, 2022).

The importance of peer support became particularly salient during the COVID-19 pandemic. The pandemic adversely affected access to in-person mental health services, especially in jurisdictions where lockdowns were enacted. Peer support services in an online format created an opportunity to maintain availability and accessibility to basic yet important community-based mental health support (Fisher et al., 2020). A number of jurisdictions increased their peer support

capacities by offering PSW training on remote services during the COVID-19 crisis (e.g., the Digital Peer Support Certification for peer specialists in the US that provided Medicaid-reimbursable virtual health services) (Fortuna et al., 2020). Virtual peer support services have been beneficial in various ways including overcoming geographical barriers, reducing regional inequalities in access to providers, and offering convenience for a wide range of vulnerable populations in communities (Moreno et al., 2020; Witteveen, 2022). Hence virtual peer support has created *bridges* allowing people in need of mental health support to access it. These bridges can be advantageous not only in crisis situations such as the pandemic, but also in non-crisis contexts by offering expanded accessibility.

There has been growing use of technology for a variety of mental health and support services with an aim to improve accessibility (Moreno et al., 2020; Di Carlo et al., 2020; Witteveen et al., 2022). However, the move to provide mental health services and support remotely, despite its many benefits, also comes with challenges. These challenges include, among others, the need for providers and service users to adapt to the utilization of diverse technologies including synchronous (e.g. video calls) and asynchronous (e.g. apps) modalities (Witteveen, 2022). We view the technological challenges as setting *boundaries* to providing, accessing and utilizing virtual services.

Existing literature does not provide adequate insight into how individuals adapt when a sudden and major change occurs from in-person to remote mental health and support services. Makarius & Larson (2017) state that the role of individuals in virtual work has been overlooked by considering them as "passive actors" (p.166) while portraying organizations as accountable for effective virtual work. They indicate that extant research on virtual work has tended to focus on virtual teams. Therefore, there is a need for greater focus on individual experiences (Baard et

al., 2014; Reyt & Wiesenfeld, 2015). This applies in a general sense, but also, specifically to peer support. With the advent of COVID-19, PSWs became one of the forefront providers of mental health support (Fortuna et al., 2020). Service users also had to adjust to virtual services. Yet limited knowledge exists about the individual experiences in the process of adapting and acclimating to using online mediums in virtual services in the context of peer support (Suresh, et al., 2021). As virtual mental health services and supports are expected to continue to be used in the future, the experiences of individuals providing and receiving virtual peer support has become an important research topic.

Another issue of importance that needs to be considered when peer support is delivered virtually is whether technology mediated connections allow peer support groups and individuals to maintain a sense of community. This sense of community is grounded in people's relationship with a group that offers them membership, fulfillment of needs, and shared emotional connection (Stewart & Townley, 2020), yet it is unclear whether the sense of community that is characteristic of in-person peer support is severed when services move online.

Earlier conceptualizations of communities emphasized the spatial dimension, defining communities as groups of people associated with a setting such as a neighborhood or village (Nistor et al., 2015). McMillan and Chavis (1986) point to earlier work (Gusfield, 1975) that distinguished between the geographical notion of community (such as a neighborhood or town) and the relational notion concerned with human relationships regardless of location. McMillan and Chavis (1986, p. 9) propose a definition of sense of community that applies to both of these conceptualizations, and is as follows: "Sense of community is a feeling that members have of belonging, a feeling that members matter to one another and to the group, and a shared faith that members' needs will be met through their commitment to be together." These authors point to

four elements in their definition: a) membership (a feeling of belonging or personal relatedness), b) influence (a sense of mattering to the group), c) integration and fulfillment of needs (a feeling that needs will be met through membership in the group), and d) shared emotional connection (a belief that members have shared history and similar experiences) (McMillan & Chavis, 1986, p. 9).

In peer support communities, the principles of valuing individuals' experiential knowledge of mental illnesses, determination for recovery, equality and reciprocity, and mutual agreement on what would be helpful for different individuals play a vital role (Mead, Hilton & Curtis, 2001; Cyr et al., 2016). People benefit in different ways by having a sense of community. They experience less isolation and social exclusion, have a greater sense of well being, can call on support when they need it and learn from experiences of other members (Rovai, 2002; Stanley, Stanley & Hensher, 2012). Cronenwett & Norris (2009) examined the role of social collectives in providing peer support services to individuals with co-occurring disorders and the benefits of social support and shared experiences in promoting recovery. However, it is not clear yet how peer support sense of community is created or maintained in situations where peer support moves to a virtual space and relationships are mediated by technological tools. To our knowledge, this topic has not been addressed despite its importance.

Given the importance of peer support and the recent surge in virtual peer support service provision, our objective is to understand how technological factors can act as bridges and boundaries to services, and whether and how a peer sense of community can be built or maintained in a virtual space that relies extensively on the use of technological tools. We aim to understand these issues from the perspective of individuals affected directly by the changes from in-person to virtual services. Therefore, we focus on PSWs who provide support services, and on

the service users or clients – also known as peers. Inclusion of peer voices is particularly important, given that this is a gap in the literature since much research on peer support is based on the views of managers and PSWs, and not on the views of the peers themselves (Walker & Bryant, 2013). This limitation in the literature applies to peer support specifically, but also more broadly. For example, a systematic review investigating implementation and adoption of telemental health found that research studies involved fewer service users compared to the number of providers (only 9 out of 45 included papers involved service users), indicating that the point of view of service users has not been adequately researched and little is reported about their experiences (Appleton et al., 2021).

Hence, we ask the following research questions: What mental health peer support needs were met with virtual services? How were technology-based boundaries manifested and what bridges were built to open boundaries? How, if at all, was a sense of community established or maintained in a virtual space? We researched these topics in the case of a peer support organization that transitioned from in-person to virtual services during the COVID-19 pandemic. While in the case we studied the move to a virtual space was a response to exacerbated mental health challenges during the pandemic, it also opened up opportunities to understand if and how peer support could be enacted virtually *beyond pandemic conditions*. The surging interest in providing mental health services and support virtually thus makes our study a timely endeavor, and our findings a valuable addition to the literature.

METHODS

Study Design and Context

We adopted an *exploratory qualitative* research approach as it allows to understand complex social phenomena and generate new insights (Miles et al. 2020). We aimed to understand participants' experiences of mental health needs within the broader social context of the pandemic, their interactions with technological aspects of virtual services, and the strategies they used to create a sense of community in a virtual space. Qualitative research based on interviews provides understanding of individual lived experiences and of strategies employed (Marshall, Rossman, Blanco, 2022).

Our primary data consisted of semi-structured interviews with employees and service users of a peer support organization based in a major city in Ontario, Canada. This organization had more than twenty compensated PSWs, some of whom held managerial positions in the organization. It served the needs of a large number of peers who sought its various services. Before the COVID-19 pandemic, this organization primarily offered in-person services that included, among others, various peer groups as well as recreational and social programs which were also intended to provide supports. We initiated the data collection in the early stages of the pandemic when work-from-home regulations were implemented in Ontario. The reason for selecting this particular case was the organization's rapid transition to virtual platforms in response to the increased demand for peer support during lockdowns and isolation.

Data Collection

We collaborated with the organization in informing potential participants about the study. An email was sent by the organization to all its employees and clients informing them about the

study, and inviting individuals interested in participating to contact the researchers. Thirteen PSWs and twenty-seven clients contacted the researchers. We interviewed all individuals who contacted us, thus our study included forty participants. Participant's' age ranged between being in their 20s and 60s, and the majority identified as female. We conducted semi-structured interviews with participants. The interview protocol included questions on individuals' mental health experiences during the pandemic, their experiences associated with opportunities and challenges of virtual services technology, the strategies that they and the organization used to capitalize on opportunities, remove difficulties, and build or maintain a sense of community. Open-ended questions enabled us to probe for additional details and allowed the participants to share beyond our questions, which provided us with rich and nuanced data (Marshall & Rossman, Blanco, 2022). The interviews were mainly done via Zoom and phone calls based on the participant's preference. The interviews were conducted during the pandemic from February to November 2021. They were recorded and transcribed verbatim.

Data Analysis

We conducted thematic analysis and used the N-Vivo software for data coding and retrieval. Specifically, we followed the steps outlined by Braun and Clarke (2006). Familiarization with the data started by both authors conducting a number of interviews conjointly, taking notes during this process and discussing the preliminary data. Familiarization was enhanced by the first author's transcription of the interviews. We then generated initial codes by immersing ourselves in the data. The long list of initial codes – or descriptive codes (Miles et al, 2020) – were closely related to participants' words. We then identified emergent themes by grouping similar codes together and reviewing that the coded extracts fit the themes. The process involved constant comparison and was iterative in that we reviewed the codes and themes and changed the theme

names when we identified emergent ideas based on new data. Analysis was mostly inductive, but we had also been sensitized by extant literature. In the later stage of the analysis, we grouped the themes into more abstract categories, continuously reviewing and refining the categories. Our final code and theme list is presented in Table 4-1.

Establishing Trustworthiness

We took several steps to establish trustworthiness of the study (Lincoln & Guba, 1985; Miles et al., 2020). Two researchers worked together on data analysis, returning to the data when disagreements emerged. This offered triangulation through involvement of multiple researchers. We also report extensive quotes from our participants as evidence of our analysis. In addition, we conducted member checking to determine whether our findings captured well the experiences of participants and thus ensure credibility of the results. This entailed sharing a draft of the manuscript with the participants and asking them to provide their feedback on the researchers' interpretation and whether those aligned with their experiences. We received feedback from two PSWs and five peers, all of whom were in agreement with the results reported. One participant commented, "*I feel that the paper captured… challenges and victories peer supporters experienced during COVID*" and another participant stated, "*It is a good in-depth work/story showing the mental health challenges and how those were addressed during the pandemic, how people evolved from their experience and stood for each other when it mattered the most*." The PSWs also provided clarifications and specifications on their organization and context, which we included in the text.

Table 4-1

Virtual mental health support services

Themes	Sub-themes	Codes
Need for Mental Health Support services	Increased need for mental health support and diminished access due to reduced in-person services	- Exacerbation of mental health issues and increased need for mental health support - Decreased access to mental health services due to persisting lockdowns
	Virtual peer support as a bridge to services	- Cost-effectiveness and convenience (free of charge, no wait time and inclusive) - Minimal logistical requirements to access - Improved accessibility for a) peers with restricting illness or conditions, b) new peers
Boundaries and bridges relating to technology-based virtual mental health support	Technology-based boundaries related to virtual services	- Difficulty with technology equipment and connectivity - Telecommunication know-how/skillset - Some peers who previously connected in-person did not join online services
	Virtual service bridges provided by the organization and PSWs	- Provision of technology & connection accessibility for providers and users - Delivering training and ongoing support - Exhibiting flexibility in operations & programs
Maintaining a sense of community through virtual mental health support services	Maintaining continuous presence and social interaction	- Transitioning rapidly to providing virtual services - Setting up social integration opportunities/programs
	Establishing multiple points of connection	- Creating a variety of virtual programs - Adding line of support via phone
	Building on organizational and peer culture	- Volunteering by peers - Leaning into peer values
	Acting collectively	- Making decisions collectively (minimal hierarchy) - Building capacity by pooling the staff's expertise
	Sharing lived experiences and learning together	- Sharing and reciprocating feelings - Learning collectively through shared stories

Research Ethics

The study was approved by the Research Ethics Board (REB) of the University of Ottawa (Reference number S-11-20-6226). All study participants were fully informed about the project through both written and oral communication, and willingly gave their consent. The consent form included information about mental health resources available to them if needed, and participants were informed about their right to withdraw from the study. All procedures followed the appropriate guidelines and regulations.

RESULTS

We begin with the results showing the need for virtual mental health support during the pandemic, and follow with the technology-based boundaries and bridges identified in virtual mental health support. In the last section of the results, we focus on the strategies that were used by the collective to maintain a sense of community despite the physical distances. It is important to note that we give attention to pandemic-related dynamics where pertinent but also go beyond the pandemic context to address more general issues related to virtual peer support that were central in our participants' accounts. We use data from peers and PSWs/managers in reporting the results.

Need for Virtual Mental Health Support

Boundaries related to accessing in-person services. The pandemic uncovered social issues that resulted in a surge in mental health challenges. Peers shared concerns regarding social vulnerabilities that became exacerbated during the pandemic. They told us about their challenges which included homelessness, domestic abuse, and struggles with addiction that were exacerbated during lockdowns. One peer referred to the "*downward spiral [of mental health]*

once the COVID-19 pandemic hit". A peer pointed out that *"literally everything shut down in the city…the needs of the community are just desperate*", and a PSW stated that *"with the pandemic, there was a lot of isolation, and it was really hard…also just the transition back as things started opening up. It's really anxiety provoking for a lot of people.*"

There was also difficulty finding mental health services as there were lengthy wait times to see a mental health professional. A peer stated: *"I think the most difficult thing was probably finding people to connect with…. There was a three-month waiting list to be able to even speak to anybody."* It is important to note that accessing mental health services in person was difficult for many people even before and regardless of the pandemic. The following quote by a peer illustrates one of many situations under which accessing in-person peer support can be difficult: *"When you have a baby, it's hard to be somewhere on time and remember to bring everything that you need and deal with the cranky baby… When your expectation is that you're going to participate in these types of groups in-person, it can be very jarring*".

Virtual peer support as a bridge. Virtual services can be a bridge connecting individuals to mental health peer support, especially when these individuals experience challenges with attending in-person peer activities. The peer who reflected above on the difficulties associated with accessing in-person peer support pointed out that "*when you can proceed in groups virtually, you can mute yourself, you can step away, your baby's crib is right there…. So it was a really wonderful option."* A peer reflecting on the high cost of seeking *"formal therapy"* and the inconvenience of doing so, pointed out that virtual peer support was *"a light in the tunnel"* for them*: "it was free, it was accessible, it was easier to find a peer support group during times that I could access it. During the pandemic I accessed more groups than I did [in person]."*

We also heard from peers whose anxieties had been exacerbated during the pandemic. A peer shared that seeking in-person mental health support was a major challenge. This person added that "*it was nice to be able to access things from Zoom. "*Considering the risk of contracting the coronavirus, peers felt that not having to leave the house gave them a *"sense of accomplishment"* because accessing services remotely helped them remain engaged. A peer noted that virtual peer support had been "*the winter month survival*" for many individuals.

Peers also told us that virtual support was helpful for them in general, and not only because of the pandemic. Social anxieties, unrelated to the pandemic, were often mentioned by participants. A peer stated:

> *I'm very timid to talk in a support group, and with Zoom, I feel I can raise my hand with the computer, and I get to speak. Whereas in a peer support group in person, I don't always get to do that. And… you get to see everybody's facial reactions when you're in the gallery view [on Zoom], whereas you can't do that when you're in the group, because I'm very shy and very anxious."*

Anxieties were also related to driving. A peer stated, *"I feel grateful I don't have to drive far or pay for parking. Without the anxiety of driving and being on time too is very relaxing… (Virtual peer support) is a blessing."* For some individuals for whom transportation to in-person meetings could be difficult due to time or financial constraints, virtual services opened the possibility of receiving peer support.

Peers also told us how the virtual services facilitated receiving support in cases where struggles with depression kept them from seeking in-person services: "*If you're so depressed, it's hard to get out of bed... That's another thing about Zoom, you don't have to worry so much about*

your appearance. If you haven't washed your hair that day, it's fine… It makes it so much easier to attend.". Virtual services were also very helpful for peers who felt they needed to seek support frequently: "*I've struggled with feeling alone and… feeling overwhelmed... If I had to go to a walk-in, I wouldn't have done it. I wouldn't have had access and that would have been bad for me*." Moreover, peers who felt self-conscious about their appearance, had experienced weight shaming, or physical differences found it more comfortable to attend virtual meetings because they *"take away the self-consciousness"* as a participant stated. By allowing participants to control what they reveal (e.g. by turning the camera on or off), virtual meetings may offer a certain sense of safety that in-person meetings may not provide.

Importantly, we were told that new members had joined virtual meetings who had not previously participated in in-person peer services. A manager pointed out that *"a lot of new people who were not previous members have joined the community to get support or to get social interaction"* and a PSW stated: "*we are supporting more people now. Our meetings are much larger. I've had people contact me from other provinces asking, 'Am I allowed to join?' We've decided that as long as we have the capacity, anybody who wants can come*."

In sum, virtual meetings offered benefits for individuals who struggled with various issues that include anxieties and depression, or whose life circumstances made it difficult for them to commute to in-person meetings. Although the pandemic (and the lockdowns associated with it) exacerbated some of the challenges that people had faced, the quotes above indicate that some challenges were not specifically pandemic related, but rather pertained to more general mental states and life circumstances. The fact that virtual meetings drew in attendance from individuals who had never been to in-person meetings is a further indication that virtual platforms increase accessibility for peers.

Telecommunication Technology for Virtual Mental Health Support: Boundaries and Bridges

Accessing virtual services offered peers opportunities to receive support, but accessing these services had its own challenges. A major challenge was the issue of technology, which manifested in terms of access to and compatibility of devices, access to internet connection, and basic technological skills. We report on these challenges and on how they were mitigated.

Virtual service technology boundaries. Technology-based challenges were associated with access to and use of equipment, access to internet connections, and limited technology-based skills. Some individuals from both groups (peers and PSWs) found it difficult to transition to virtual services due to the unprecedented complexities introduced by the new service environment: "*the hardest thing for people is the technology part of it*." The experience of change to virtual services was described as "*anxiety provoking*" for people who were not familiar with the use of technology such as computers and smartphones in daily life.

Accessing virtual services required the use of the appropriate equipment such as smart phones, and for some peers, access to these devices was a challenge. A peer described: "*The devices that I had access to were lower-end devices... My cell phone was blocking out and freezing*". Another peer stated: "*I would drop in occasionally using my phone. But I didn't have a computer, and currently I'm receiving disability benefits… As far as having money to burn, that's not an option for me, it's a very tight situation*". In addition, lack of access to and reliable internet connection was another boundary. A participant described the lockdown situation: "*It was a big shock. It's a big change. It's forcing a lot of people who didn't have Internet to get Internet. So that caused a lot of stress and strain on a lot of people*". Peers who shared an

internet connection with multiple residents had to coordinate schedules since simultaneous Zoom calls could interrupt connections.

For some individuals, lack of technology-based skills was a boundary. Some peers had difficulty navigating the nuances of the various platforms and their compatibility with the devices they were using: "*You had to figure out what platform was used and whether or not your technology was going to be compatible with it.*" Other peers experienced difficulties early on with logging in and accessing meetings: *"[It was a] struggle with the process of getting signed up, to get the notifications, to get the information*". Others reported difficulty navigating the programs' options during the meetings (e.g., using the raise hand option).

The challenges did not only pertain to peers. PSWs also faced difficulties with technology: *"I did not have the technology needed to be able to do my job from home. I had a smartphone, but it's still very challenging to host a Zoom group when I can only see 4 little faces on a screen."*

Virtual service bridges: Supports provided by the organization. When the lockdowns were mandated, concern about peers' mental health needs drove the organization to create a variety of platforms through which peer support services could be accessed. Within few weeks, the organization created remote services to maintain continuity in support for peers. A PSW pointed out *"They were relying on us for their well-being."* This created a sense of urgency to adapt quickly in order to meet the needs of the community.

Efforts were quickly deployed to connect with peers by phone and to create accessibility through online options. As a peer stated, they were "*trying to make things just as accessible as*

they could be". To this end, the organization engaged in advocacy efforts with external partners to provide devices, data, and internet connection to those without technology. A manager stated:

> *"Many people with mental health and addictions don't even have access... We have been providing people with tech and tablets and smartphones and connectivity, and we're a peer agency, we don't have this kind of stuff! ... I kept raising it at our (regional health authority) table with a lot of people who are very high up. And they said, 'Let's do it'! So we applied and put together a proposal… We now have contracts with [internet] providers, so [one company] provides the smartphones with sim cards and [another company] provides the tablets."*

PSWs walked the peers step by step through the Zoom functions that they needed in order to attend and participate in virtual meetings. A PSW pointed out:

> "*We did a lot of one-on-one training and coaching and mentoring with people to help them get their virtual equipment set up. At first, it was a lot of, 'this is how you set up Zoom, this is how you set up your camera' … and then more people got comfortable using it*."

PSWs also received training and support. Training included group and one-on-one sessions, and manuals were made available to provide instructions for an online environment:

> *"In the beginning, we had training from a staff member who is a certified online facilitator... and it walked us through how to use Zoom. I also had a one-on-one training… to walk me individually before doing any online groups… I asked my questions, and felt comfortable then to roll with it, [and] manuals were written with the policies of how we were gonna do this online."*

The social media team of the organization also became very active during the early days of the lockdowns. A manager who was part of this team described the role of the social media team:

> *"We re-did all the posters we had for in person, we switched them to virtual, giving new contact information, laying out the registration process…Every day we posted what groups we had going on, and all of that content had been created after the pandemic started. Again, a lot of that very quick adaptation to the needs."*

We were also told that the organization added and adjusted online group activities and services as the lockdown policies and the needs of the peer community changed.

In sum, the findings show the challenges and solutions relating to using telecommunication technology for virtual mental health support during the COVID-19 pandemic. Accessing and providing these virtual services required access to and compatibility with devices, reliable internet connection, and technology-based skills, which could be challenging for some individuals. To address these challenging access boundaries, the organization arranged to provide devices, data, and internet connections, along with training and ongoing support to both peers and PSWs. Meanwhile, the organization also experienced a learning curve as it was adapting to the new circumstances and applied efforts to bridge the gaps in service access.

Maintaining a sense of community in a virtual space

The peer support community already existed before the pandemic lockdowns. Peers would come to the organization locale for in-person services and programs, and many relied on these programs for mental health support. The lockdowns were disruptive of the in-person programs, which had to be halted, and as we elaborated earlier, the organization quickly responded by establishing services online. We were interested in whether and how a sense of community could

be re-established and maintained in a virtual environment. Our findings point to five strategies in which the organization and the peers engaged, and which enabled maintaining a sense of community. We present these strategies next, and would like to point out that although we discuss them separately to facilitate the presentation, these strategies were not mutually exclusive.

Maintaining continuous presence and social interaction

In a context of increasing isolation, and to meet the needs of peers, the organization quickly began to offer phone services whereby peers and PSWs could connect by phone. Participants told us the phone support communicated a sense of caring and had a significant impact on individuals' mental health during the pandemic. One of several volunteer peers who took on the task of checking on other peers regularly, indicated that for some individuals, their only connection to the outside world was through these phone calls: "*It could mean the difference between being stable and unstable... Being unstable for a long time could lead to something terrible*." Phone calls were not only about mental health topics, but could also include friendly conversations about daily living activities, which solidified relationships. The peers looked forward to these phone calls as a means of getting positive contact with someone who cared to listen. As one peer said, *"They opened up a phone line and… I would call almost every day… I really needed [peer support] So having that as a service was really, really good."* And another peer stated: *"[It was great] knowing that they're always there. It's just the comfort of knowing there's someone to reach out to.*"

It is important to note the speed with which the organization was able to adapt and to create programs that met the peers' needs, thus maintaining a continuous presence. As a manager stated, "*[peer support] works well in a pandemic because we were able to be more flexible."* This is in

contrast to institutional mental health services that were subject to various regulatory restrictions that would delay the introduction of online services. A PSW stated, "*we are extremely adaptable."*

In short order, the organization created a variety of online groups and activities in which peers could register and participate. These programs allowed the peers to continue interacting and engaging with one another. The sense of community was palpable even for peers who did not participate actively in the programs:

> *"So for these people [like me], even though their videos and microphones are off, being immersed in the group, feeling like, hey, I'm not the only one, these are my people… and they look good and they're talking and they're feeling great. I feel good being there. And I may not want to say anything. It's amazing. It's a good feeling."*

Another peer commented on the relationships with the PSWs in the virtual meetings and said "*…you can access [virtual support] anywhere and see the facilitators that you're connected to. And that sometimes is enough to just make my spirit go fly.*" A similar sentiment was communicated by PSWs, one of whom stated: *"We have things seven days a week that peers can come and join us. That has been really great; [it] helps keep the sense of community because we have that touchpoint with them. "*

Establishing multiple points of connection

The organization was intent on meeting diverse needs of peers, and to this end, created a variety of virtual programs and groups as well as phone services. In addition to the mental support groups, there were special activities such as yoga, crafting, and cooking, all of which instigated mutual support. These various activities could draw in diverse people who shared

similar interests, creating online communities. Peers stated that despite the lack of one-on-one eye contact, they found online groups were effective in offering valuable social activities related to wellness, nutrition, parenting, and gender-based support. One peer noted, "*They have a variety (of services) … Sometimes I'm in the mode of meeting [people] or joining arts and crafts. Sometimes I join the trivia online."* Another peer indicated that it was possible *"to find the niche of the thing that you were looking for*" and a third peer stated: "*the trivia for me is very engaging … everybody can play.*"

Availability of multiple points of connection implied that the peers and PSWs could remain connected to each other on a regular basis. Another initiative by the organization to encourage this sense of community was the creation of a Facebook group. Due to the variety of points of contact, new members joined as they learned about the virtual services, expanding the community. However, the main aim of the organization remained to continue providing mental health support. A manager stated:

> *"A lot of what people wanted was social connection, which we do offer in recreation. But we're a support-based organization, and even our recreation has some support components to it. We came up with this private Facebook group which has helped a lot with that because people can stay in touch, not just with facilitators or with a group in a moment, but they can talk to each other whenever they want should they choose to join. "*

Building on organizational and peer culture

Participants pointed out that peer culture is permeated by care and concern for members, and this was clear in various quotes we reported above from managers, PSWs and peers. In fact, managers and PSWs are also peers and they pointed this out continuously during our study. For

example, a manager stated: "*It's very helpful when peer support is informed by a community of people. And when peers can run some of their own services and see that peers are not only people who are recipients of services but actually are also managers*". This manager also pointed out:

> *"A peer-run community of peer supporters can help people meet different needs: their creative needs, their social needs, their support needs. There are physical needs, we're doing some walking. We're supporting people to get technology so they can not only take part in our Zoom meetings but also order their own groceries online or maybe they can talk to their doctor online now. Peer support has a lot of strengths."*

Another manager noted, "*It's never just a job for people [at the organization]. It's about how we can create something that is going to benefit the people who need it*." This focus on helping and supporting each other was integral to the organization's mission and culture. This focus was shared by peers. Increased involvement of peer volunteers, who were not paid by the organization, in running services including the voluntary phone line was highlighted as an example of peer values and practices. A manager explained, "*One of the things that's really important is to rely on the people who are actually DOING the thing, as opposed to me saying "well I know what's good for this", but actually leaning into our values*." Various participants mentioned that the implementation of online mental health support during the pandemic was an indication of resiliency in the peer support community. A peer stated "*We weren't able to meet face to face. So people took it upon themselves to set up and organize these meetings and to learn how to use the technology to provide those services.*"

Acting collectively

The sense of community was also enabled by how decisions were made in the organization and with the help of peers. Deciding and acting collectively helped maintain a sense of community in the virtual space. This approach was especially effective during times of disruption that affected the organization and the peers. Overall, the organization's collaborative approach to decision-making and focus on benefiting those in need were key components of its success.

The organization relied on discussion-based decision-making, with all staff members coming together weekly to discuss various issues and make decisions for the week. The management approach was collaborative and non-hierarchical. A manager said, "*We make decisions with the management collectively, and at times, when it's appropriate, we make decisions with all staff*." Another manager described how "*the hierarchy felt a lot flatter"* during the pandemic and the priority became *"Who's got what competencies? Who's got what skills? Bring them in!"*

Different members of the organization contributed their knowledge and skills to enhance capacity to move services online. A PSW said: *"We all bring our own perspectives. So I said my specialty is looking at the programming and the scheduling and what is feasible for us as staff … it was a lot of communication."*

Sharing lived experiences and learning together

Peer support is based on shared lived experience of individuals. Sharing these experiences helps build bonds among peers. We were interested in how the virtual environment could have affected the sharing of experiences. Although some peers pointed out that they found it easier to

share experiences in person, others – as we showed earlier – indicated that the online environment made it easier for them to participate. A PSW indicated:

> *"We offer that space to just connect... Even though we're saying "You gotta raise your hand before you talk" – that was an adjustment period. But now it's the norm… That sense of belonging comes from connecting around shared lived experience. So connecting around that shared lived experience is still happening. It's just virtual, and a little more systematic."*

A peer described how the shared lived experience was helpful when using virtual services during the pandemic: *"The ability to participate with other people who are struggling [was helpful], I just think that sharing those feelings and hearing that you're not alone was worthwhile to me*". Another peer reflected on the importance of the virtual services for connection around shared experiences of feeling "lost": *"It was a wonderful place to connect with people who were also struggling, when everybody was sort of lost and in the same boat".*

Shared experiences were not limited to feelings of being lost and struggling. Members were also learning together, which solidified the sense of community. A peer pointed out: *"[Relationships] became stronger in a sense, because we were all in the same boat… Sometimes the facilitators themselves were like I don't know how to do that. We were all learning …and figuring things out. And I think that's a good way to become closer to people.*"

In sum, various strategies were used by the organization and the collective (including PSWs and peers) to build and maintain a sense of community that was anchored in peer culture values.

Continuation of Mental Health Support through a Hybrid Mode: Importance of Combining In-person and Virtual services

Virtual peer services were "a lifeline" especially during the pandemic, as a peer noted. However, some peers also looked forward to returning to in-person services for various reasons. For some, the in-person services provided structure to their week and a chance to leave the house. A peer noted: *"It forces me to get out of the house...I'm having difficulty leaving the house...half of me looks forward to it [the weekly support meeting], and half of me dreads it. But in the end, I get myself out of the door and I walk up to the center...I feel so much better afterwards."*

Naturally occurring conversations during coffee breaks or after the meetings, which contribute to supporting relationships, were missed. As one peer stated, "*A lot of it [peer support] is the action piece and when you're connecting virtually, it's just not the same as being in person*". Some participants pointed out that in-person interactions offered a deeper level of connection through shared energy and physical space. A participant noted,

> "*When someone's super upset, you can feel it. When people are in their own homes, it feels disconnected because there are so many other people there. I feel like we're seeing less emotional distress, whereas in-person, it would be brought out – and not distress in the sense that they're not coping, but that they're bringing big feelings or things on their mind and they're expressing them freely in person. I feel there's a lot less of that since being virtual*."

Additionally, some participants felt *"strange"* expressing strong emotions through a computer screen and pointed out that virtual settings offered less authentic connections compared

to in-person interactions. Nonetheless, participants acknowledged that some people could still struggle regardless of the mode of interaction.

It was also pointed out that although virtual events drew in people who had never attended in person, some peers who used to attend in-person meetings did not join any virtual meetings, and it was not clear why this was the case or how they coped with the pandemic. Some of these individuals could not be found on online platforms to connect with. A participant stated, "*…there's a whole voice of those who can't access virtual, those who have only been going in-person... So I think we definitely should try to cater to both [when designing mental health support services*]".

Overall, peers expressed support for maintaining remote online mental health peer support services even as lockdowns were lifted, and pointed out that transitioning to a hybrid mode would offer efficiency in resource utilization and greater convenience for remote access. A peer emphasizing the need to continue the virtual services noted the importance of social integration for peers with disabilities: "*I think there's a lot of people, especially with disabilities or just more issues who have a really hard time going in person. I feel like there's a lot more people who were able to access services and I don't think that they should just be cut off and done.*" Those living on the outskirts of the city or with other commitments had limited time to attend in-person support meetings, making hybrid services desirable after pandemic restrictions were lifted. Online meetings made mental health services more accessible, allowing individuals to manage their work-life domains more harmoniously. A peer said: "*...People are always finding it a stress release and I like accessing it (peer support) from home sometimes instead of having to go to places…Sometimes I'm just not into seeing people or going out and dealing with traffic."*

In sum, continuing with virtual services while also maintaining in-person services was seen as offering more access to peer support services to a broader population, and as providing more choice for individuals who sought peer support.

DISCUSSION & CONCLUSION

This study contributes to the literature in a number of ways. It emphasizes the importance of providing virtual peer support in situations where mental health in-person support and services are not possible or accessible. We have highlighted the technology-based challenges and opportunities that create boundaries and bridges respectively to peer support in a virtual space. We have shown that a hybrid model involving both virtual and in-person services offers better accessibility to individuals and groups in need of support, and have argued for the importance of maintaining both modalities. We have also shown that a sense of community can be established in a virtual space, and have highlighted the strategies that peer organizations and their members can utilize to maintain the community spirit. As importantly, we have contributed to the literature by including peer voices and highlighting their experiences in their own words. Researchers have pointed out that the experiences of service users have not been adequately researched (Appleton) and this is particularly so in the case of peers (Walker & Bryant, 2013). Our research enhances understanding of service users' lived experiences.

A Hybrid Model of Peer Support Services

Our findings show, consistently with the literature, that each of virtual and in-person peer support service has its own advantages and disadvantages when used singularly, and that the joint operation of virtual and in-person services through a hybrid model provides more accessible service (Strand et al., 2020). Using both approaches conjointly offers the opportunity to

strengthen community-based mental health, and to reinforce recovery approaches that promote individual choice and self-determination. The importance and benefits of peer support and recovery approaches have been documented (Piat et al, 2022) and have been implemented increasingly across countries around the globe (WHO, 2021). A hybrid model benefits service users in that during health system crises, such as a pandemic caused by an infectious disease when mental health needs are higher, access to mental health support can be maintained. Overall, this model offers promising potential as a vital resource to support the mental well-being of populations.

Using both models conjointly benefits not only service users and communities, but also organizations that support mental health. By maintaining and strengthening both types of services, organizations that provide mental health services can build their capacities and be better prepared for sudden changes that might require suspending or limiting in-person services. This enhances flexibility and adaptability by maintaining a system that can dynamically switch between the two modalities.

Yet, despite the benefits of maintaining virtual services alongside in-person services, some PSWs and peers in our study reported a number of technology-related challenges that included difficulties obtaining internet connection or proper equipment, as well as limited skills with respect to use of technology. Our findings are consistent with research which shows that providers and users of virtual mental health services report several limitations, such as difficulties with the adoption of the remote practice, and access and literacy challenges (Costa et al., 2021; Kane et al., 2022; Pierce et al., 2022; Yue et al., 2020; Witteveen et al., 2022). Our findings also show that to be effective, a mental health support system that utilizes a virtual mode of service delivery requires appropriate technological tools and infrastructure, as well as

appropriate supports. In the case we studied, the organization advocated for and obtained access to internet and equipment for peers. Further, the organization allocated extensive time to training of PSWs and peers. PSWs, once versed on the use of the technology, offered help to peers in group settings and one-on-one when necessary. This kind of assistance and collaboration is common in peer support communities, where principles of mutuality and cooperation prevail, but this also suggests the importance of providing adequate resources to peer support communities so they can achieve their full potential.

Another challenge associated with the virtual environment is that computer-mediated communications provide fewer social context cues; hence individuals who join an online community may experience less personal connection (Rovai, 2002). This challenge was identified by some of our participants, prompting us to ask how a sense of community may be established and maintained when peers connect virtually. We turn to this next.

Sense of Community

Ilioudi et al. (2012) refer to virtual communities in health care as "a group of people using telecommunication with the purposes of delivering health care and education, and/or providing support" (p.1). These communities encompass a wide range of clinical services and technologies. During the COVID-19 pandemic, there was increasing attention to online recovery services and phone support, self-help and mental health self-management delivered virtually or in e-communities (Fortuna, Solomon & Rivera, 2022). E-communities are critical for mental health support and have the potential to transform the philosophical approach to the provision of mental health services as they help bridge the gap between the high prevalence of mental health challenges and the relatively low capacity of mental health systems (van Os et al., 2019).

In peer support communities, individuals share experiential knowledge to encourage and pursue recovery as a mutual goal, showing common purpose and interdependence (Davidson, et al., 2012; Solomon (2004). Despite many peer support e-communities having been set up and having flourished during the COVID-19 pandemic and thereafter, there has been limited research on how the sense of community can be established or maintained in these groups. In studies of groups and communities more generally (and not only in the case of peer support), there has been focus on applying quantitative measurements and scales for the assessment of the sense of community, e.g., the Brief Sense of Community Index (Long & Perkins, 2003), and the Brief Sense of Community Scale (Peterson et al., 2008). These scales have been applied to study academic communities of practice (Nistor et al., 2015), online education programs for different groups (Shea, Richardson & Swan, 2022; Baxter & Hainey, 2023) and for individuals with serious mental illness living in community settings (Townley & Kloos, 2009). However, less research applies qualitative methods to explore in more depth this sense of community.

Literature shows that a sense of community is important in mental health support, especially during crises such as the COVID-19 pandemic (Bowe et al., 2020). A better understanding of sense of community in virtual services could uncover factors that contribute to a positive therapeutic environment (Kitchen, Williams & Chowhan, 2012). Our results identified five strategies to maintain a sense of community amongst peers and providers in a virtual environment during the COVID-19 pandemic. These findings highlight the importance of having a holistic and multidimensional perspective where the organization, providers, and peers all play a role.

The strategies we identified resonate with McMillan and Chavis' conceptualization of a sense of community. Their conceptualization highlights four elements: a) membership (a feeling

of belonging), b) influence (a sense of mattering to the group), c) integration and fulfillment of needs (a feeling that needs will be met through membership in the group), and d) shared emotional connection (a belief that members have shared history and similar experiences). By "*acting collectively"* (as in our findings), individuals reinforce the notion that they belong to a community where their contributions matter and are valued. Acting collectively also allows the community to fulfill common needs. "*Building on organizational and peer culture*" involves recognizing the contributions of individual members that could reinforce the belief that each member has a meaningful impact on the community. This culture is inclusive and fosters integration and emotional connection among the members. "*Establishing multiple points of connection*" ensures that community members have diverse channels to interact, collaborate, and meet their needs. "*Maintaining a continuous presence and social interaction*" helps establish trust that membership in the community is a reliable path for meeting their needs. Finally, "*sharing lived experiences and learning together*" allows members to open up about their mental health (or other) challenges, contributing to an emerging collective narrative and shared history. Other organizations attempting to build or maintain a sense of community in a virtual space may find some of these strategies employed by the organization, the PSWs and the peers to be helpful.

Limitations and Directions for Future Research

Our study has a number of limitations. Concerns regarding security and privacy in virtual health care communities have been highlighted in research (Moreno et al., 2020, Lustgarten et al., 2020). Researchers have also pointed to potential conflicts within online communities set up for various purposes (Ferguson & Taminiau, 2014; Hauser et al., 2017). Our paper did not examine these privacy and social concerns, however, evidence regarding these topics is

important to provide guidance on how to make virtual spaces safe for peers who participate. Future research on these topics would be useful.

In addition, our findings pointed to peer support users who did not access the mental health support services when these transitioned to virtual platforms. We did not have access to these individuals, and it is not clear what factors contributed to their absence. Future research may explore whether and how technology-based boundaries become an impediment to seeking mental health support for some individuals. We also need a better understanding of the mental health of individuals who stopped using peer support when services moved online.

Our study focused on an organization and its members (PSWs and peers) and did not include in-depth attention to macro system level influences on peer support in a virtual space. Future research may identify and address system level influences that can hinder or facilitate mental health virtual services within community organizations, and how the needs of and services provided by these organizations may influence allocation of resources and mental health indicators at a systems level.

Implications for Policy and Practice

Our findings highlight the organization's efforts to provide accessibility and support for both peers and PSWs and demonstrate the value of a proactive and responsive approach to addressing major change. Organizational and management support has been identified as a central factor in employees' readiness when change occurs in an organization (Austin, Chreim & Grudniewicz, 2020). In fact, the COVID-19 pandemic situation highlighted the adaptability and resilience of peer support services and communities. As a manager in our study pointed out, the peer support organization was able to quickly and flexibly respond to the sudden surge in the need for mental

health support at a time when more institutionalized and strongly professionalized services were struggling to adapt. The resilience and adaptability of peer support organizations and programs are strengths in mental health care systems that are struggling to meet the needs of populations (WHO, 2021), yet these organizations and programs often receive a relatively small share of health care resources. Future policy may consider a more equitable allocation of resources to peer support services.

Another policy-related implication pertains to technology infrastructure and more specifically to who gets access to devices (such as smart phones and computers) and to internet connections. Our study highlighted that lack of access to these resources was a boundary that challenged some peers seeking virtual support services. The peer support organization stepped in to create bridges by advocating with funders and tech providers. However, this leaves unsolved an issue that needs to be addressed at a higher societal level, namely the limited, yet necessary, resources available to some segments of the population (typically homeless individuals, people with disabilities, refugees, and other groups). This issue should be an important consideration in future policy.

Finally, our study pointed to several practical implications based on the experience of the case we studied. For example, we pointed to the various strategies that peer organizations can use to maintain a sense of community in a virtual space. Further, in anticipation of growth of virtual peer support services, organizations may consider the need for renewed training modules that integrate necessary skills relating to using technology for recovery support. Peer support organizations may also consider building their capacity to respond quickly to crises and major changes, as it is during these situations that their services may be in most demand.

Conclusion

The important role of mental health community services and the changing drivers in mental health systems have been noted by researchers. Norton (2023) points out that "*mental health services are currently undergoing immense cultural, philosophical, and organisational change. One such mechanism involved in this change has been the recognition of lived experience as a knowledge subset in its own right*" (p.1). The trends of peer support gaining in importance and being delivered in virtual as well as in in-person spaces are poised to continue in the future. It is incumbent on researchers to continue studying the challenges and opportunities of peer support in its various models. Our study has been a step in this direction.

LIST OF ABBREVIATIONS

PSW: Peer Support Worker

UK: United Kingdom

US: United States

WHO: World Health Organization

REB: Research Ethics Board

DECLARATIONS

Ethics approval and consent to participate

This research involving human participants was granted ethical approval through the Research Ethics Board (REB) of the University of Ottawa (Reference number S-11-20-6226). We confirm that all methods were carried out in accordance with relevant guidelines and regulations.

All participants in the study were given oral and written information about the project, and they provided informed consent. In the consent form, we provided resources for mental health support in case of need. In addition, the participants were informed of the possibility of withdrawal from the study.

Consent for publication

Not applicable.

Availability of data and materials

The dataset used in this research is not publicly available as set out by the research ethics approval from the University of Ottawa and the consent forms signed by the participants. Further information is available from the corresponding author upon request.

Competing interests

The authors have no relevant financial or non-financial competing interests to disclose.

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Authors' contributions

This article is part of EM's doctoral thesis. EM and SC contributed to the study conception and design. Data collection was done in collaboration, and analysis and manuscript drafting were performed by EM, and were thoroughly reviewed by SC. Both authors critically revised the drafts until finalized.

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CHAPTER 5

DISCUSSION and CONCLUSION

This section presents an integrative overview of the three Essays in this thesis. It provides an overview of each of the three Essays, after which the linkages across the findings from the Essays are addressed through a reflection on the challenges associated with the PSW role, followed by the opportunities for the PSW role and for peer support more generally in mental health systems. Following this, the contributions, and implications of the thesis to policy and practice are discussed. Next, the limitations of this thesis are discussed and directions for future research are highlighted.

The Three Essays

In the first Essay, a thorough exploration of multilevel factors influencing the formal implementation of the PSWs role in mental health systems is conducted. Factors at macro, meso, and micro levels, along with their interactions, are systematically reviewed and synthesized, offering a foundational understanding of the complexities surrounding PSW role implementation. Following the occurrence of the COVID-19 pandemic, the thesis focus turned to the examination of roles and experiences of PSWs and service users when offering and receiving virtual services. The second Essay delves into the specific challenges faced by PSWs enacting their roles virtually from home during the COVID-19 pandemic. Through an empirical qualitative study, it investigates the work-life boundary challenges encountered by PSWs working from home and explores their boundary management strategies. The third Essay extends the empirical inquiry and examines the experiences of both service users and PSWs during the COVID-19 pandemic. It investigates the mental health peer support needs met through virtual services, the

manifestations of technology-based boundaries and how those were overcome, and the strategies employed to maintain a sense of community in a virtual space. Table 5-1 provides an outline of the Essays that includes the research questions, methods and key findings.

Challenges Identified for the PSW Role in the Mental Health System

Based on the findings of this thesis, this section discusses the identified challenges for the PSW role in the mental health system. The challenges are discussed through a multilevel lens.

At the macro level, several challenges impede the successful implementation of the PSW role within the mental health care system. One of the most prominent challenges arises from the power dynamics entrenched in the hierarchical system of health professions (Repper & Carter, 2011; Ehrlich et al., 2020). Moreover, policies designed to facilitate the integration of PSWs into mental health teams and certification programs vary in effectiveness. While some jurisdictions have implemented policies and certification programs (Grant et al., 2012; Byrne et al., 2019), the evidence regarding their impact remains mixed. Ensuring that policies translate effectively into practice at the meso, and micro levels is a persistent challenge, as tokenism and limited role recognition can hinder the meaningful engagement of PSWs within the system (Siantz et al., 2016; Ibrahim et al., 2020). Discrimination towards people with a history of mental illness engenders resistance to their role implementation and acceptance (Walker & Bryant, 2013; Byrne et al., 2019). Economic uncertainty, whether at the national or jurisdictional level, also presents a challenge (Ibrahim et al., 2020), but it has not received sufficient attention in the literature. Similarly, the fiscal aspects of PSW employment, including the financial return on investment and social returns in terms of recovery and reduced stigmatization, require further exploration. Lastly, the role of gender in the implementation of PSW roles remains understudied at the socio-cultural level as well as the meso and micro levels, leaving unanswered questions about how

gender stereotypes may affect hiring, remuneration and integration practices within the mental health care system. This is in view of the fact that a study by Ved et al. (2019) highlighted that female community workers often receive relatively lower wages compared to their male counterparts.

At the meso and micro levels involving organizations, teams and individuals, this thesis demonstrated a multitude of challenges that affect PSWs' role and impact their overall well-being. While some role challenges are based on literature before the COVID-19 pandemic, the thesis also attended to role challenges that occurred during the pandemic. According to the synthesis of the literature before the pandemic, PSWs' role potentially encounter a range of challenging factors stemming from the organizational level (i.e., the culture, leadership, change management capacity, and human resource management policies), team integration and relationships with staff, and individual challenges to sustain their wellbeing. The findings pointed to the interplay among various factors when implementing the PSW role, especially when translating system-level policies and strategies into organizational and team-level practices (Mulvale et al., 2019). Among the steps intended to ameliorate meso and micro role challenges are consultation and engagement with those involved in the PSW role implementation (Chinman et al., 2010).

The findings of this thesis identified challenges during the pandemic relating to work-life boundaries and technology-related obstacles in enacting the PSW role after transitioning to virtual space. The sudden shift in PSW role created a situation of uncertainty and confusion, blurring the lines between work and personal life when working from home. Virtual work led to work-life boundary challenges of temporal, physical, and task-related nature. The disruptions had

far-reaching implications as highlighted by other studies about health care workers indicating augmented workload, strain and blurred work-life boundaries (Chemali et al, 2022; Humphries et al., 2020; Koontalay et al., 2021). Constant accessibility to work-related tasks encroached upon personal time, contributing to an imbalance between professional and personal life. Such imbalances have been shown to trigger an adverse impact on employees' overall well-being (Dettmers, 2017; Cabiati, 2021). The blurring of physical boundaries led to the co-presence of household members in the workspace, adding complexity to the work environment, especially considering PSWs' role requirement to have private spaces for confidential conversations. Further, navigating the needs of their clients, co-workers, and family members created task-related boundary challenges for PSWs.

The work-life boundary challenges of PSWs during the pandemic necessitated a rapid adaptation of their role to a new work situation and the use of boundary management tactics (Kreiner et al., 2009). PSWs engaged in two strategies to manage work-life boundaries including segmentation (separating timescapes, spaces and tasks) and integration (adopting selective permeability). The segmentation tactics are important for individuals' well-being in terms of detachment from and restoration after work (Wepfer et al., 2018). The findings regarding the integration preferences of the PSWs emphasize the individualized choices of employees in terms of how much permeability would work for them. PSWs played an active role in determining the extent by which work and life domains are permeable. This heterogeneity of individual choices is also identified by Elbaz et al., (2022) in a scoping review of work-life balance during the COVID-19 pandemic. These findings indicate the importance of having autonomy in enacting some aspects of the PSW role when working from home.

In addition to work-life boundary challenges, the PSWs and the organization that were examined in this thesis grappled with technology-related barriers to providing peer support services. Besides the impact of this change on PSWs, the findings of this thesis showed that the mental health of service users deteriorated during the lockdowns of the pandemic, and in the meantime, the accessibility to in-person services became difficult. Considering these contextual factors, PSWs' continuity of role became imperative as virtually delivered recovery services and e-communities for mental health self-management became more prominent (Fortuna, Solomon, Rivera, 2022). This thesis conceptualized the technology-related barriers and opportunities related to the PSWs as access boundaries and bridges associated with peer support services in virtual space. The boundaries in the adoption of virtual services stressed the critical need for adequate technological infrastructure, and training to support PSWs in their roles, particularly when a hybrid model of services continues after resumption of in-person services (Strand, Eng, Gammon, 2020). In addition, these challenges were relevant to the organization that supervised the PSWs in navigating the new form of work from home, while also dealing with macro influences such as resource constraints and prioritization of professional services.

In conclusion, macro, meso and micro-level role challenges faced by PSWs before and during the COVID-19 pandemic highlighted in this thesis offered an interlevel perspective for a more comprehensive understanding of their role dynamics and the role of their organizations in the mental health system.

Opportunities for PSWs' role and peer support services

Despite the mentioned challenges, there are opportunities for PSWs' role and peer support services to enhance the mental health care system.

As PSWs developed an enhanced awareness of work-life boundaries when working from home, they leveraged their understanding to proactively implement various tailored boundary management strategies including time management, workspace optimization and effective organization of work-life task boundaries. The work-life literature highlights that employees actively play a pivotal role in shaping and defining boundaries between their work and personal lives (Kreiner et al., 2009; Rothbard and Ollier-Malaterre, 2015). The findings of this thesis showed that PSWs had innovative approaches to boundary management. They created distinct timescapes, physical spaces, and task-related boundaries. Furthermore, the findings regarding the importance of PSWs' boundary management tactics on their overall well-being indicate that their lived experience of virtual work will be invaluable for the future of their role since virtual work continues to influence the healthcare landscape. The enhanced awareness of PSWs about their work-life boundaries in virtual work will enable them to promote the creation of hybrid models that minimize boundary challenges.

This thesis revealed the remarkable adaptability and resilience of a peer support organization and the PSWs to quickly transition services to virtual space during the pandemic. This process highlighted the ways in which PSWs, and the organization created bridges towards providing accessible community-based services— through virtual service including a phone support line, various online programs, ongoing technical support, and social media presence. The PSW role flexibility suggests several benefits for the mental health system. First, their services can be maintained when mental health conditions deteriorate, and these services reach marginalized individuals who otherwise have limited or no access to mental health support. Last but not least, virtual peer support services offer promises beyond the pandemic conditions. This thesis unveiled the significance of building and maintaining a sense of community in a virtual space for

people who need mental health support, and the importance of the PSWs' role in fostering this sense of community. The sense of community was preserved through the strategies of maintaining continuous presence and social interaction, establishing multiple points of connection, building on organizational and peer culture, acting collectively, and sharing lived experiences and learning together. The findings showed that maintaining a sense of community is vital for peer support services no matter the modality of service provision.

In sum, this thesis contributes to a nuanced understanding of challenges and opportunities associated with the role of PSWs, and the importance of peer support in mental health systems, providing a basis for informed decision-making and policy development.

Table 5-1

A Summary of thesis Essays: Research questions, methods, and results

Thesis Essays	Research Question(s)	Research Methods	Results
Essay 1: A Narrative Review of Factors Influencing Peer Support Role Implementation in Mental Health Systems: Implications for Research, Policy and Practice	What are the multilevel factors that influence the formal implementation of the PSW role in mental health care? How do these factors interact across levels?	Narrative Review Synthesis - Database search and PRISMA - Quality assessment - Inclusion of 38 articles meeting inclusion criteria. *Period*: Pre- COVID-19 pandemic *> Thematic analysis:* *An interpretive approach* - Identification of first and second-order categories across studies. - Development of third-order interpretations through iterations. - Synthesis applying a multilevel framework - Tabulation of findings	*Influencing factors on PSWs role implementation:* *> Macro level:* Broader socio-cultural factors: Medical model, recovery values, professional power dynamics, training and certification Regulatory and political factors: Policy mandates, political commitment Economic and financial factors: Funding, affordability of services *> Meso level:* Organizational culture, organizational leadership, change management, and human resource management policies. *> Micro level:* Relationships between PSWs and team members, PSW wellbeing *> Interlevel interactions and implications are outlined.*
Essay 2: Work-Life Boundary Management of Peer Support Workers when Engaging in Virtual Mental Health Support during the COVID-19 Pandemic: A Qualitative Case Study	What work-home boundary challenges arose for PSWs when working virtually from home during the COVID-19 pandemic? How did PSWs manage the work-home boundary challenges?	Qualitative Case Study *Interviews* with PSWs (13) who held formal, paid positions (via Zoom). Some PSWs were also managers. *Case*: A community peer support organization, in Ontario, Canada *Period*: Early COVID-19 pandemic *> Thematic analysis:* *Inductive and deductive* - Descriptive coding: Utilized participants' words. - Inferential coding: Synthesized conceptual categories informed by boundary theory - Member checking	*Work-life boundary challenges:* > Temporal boundaries -Work schedule encroachments, - Continuous online presence > Physical boundaries - Minimal workspace segregation, - Co-presence of household members and pets > Task-related boundaries - Intersecting work-home activities *Boundary management strategies:* > Segmentation of work-life domains: Creating separate timescapes, spaces and tasks. > Integration of work-life domains: Selective permeability between work-life interface

Thesis Essays	Research Question(s)	Research Methods	Results
Essay 3: Transcending Access and Technological Boundaries and Maintaining a Sense of Community in a Virtual Space: The Case of Mental Health Peer Support	What mental health peer support needs were met with virtual services? How were technology-based boundaries manifested and what bridges were built to open boundaries? How, if at all, was a sense of community established or maintained in a virtual space?	Exploratory Qualitative Study *Interviews* with service users (27), and PSWs (13) who held formal, paid positions (via Zoom). Some PSWs were also managers. *Site*: A community peer support organization, in Ontario, Canada *Period*: Early COVID-19 pandemic *Thematic analysis:* *Inductive and deductive* - Descriptive coding: Utilized participants' words. - Inferential coding: Synthesized conceptual categories informed by concepts of virtual services and a sense of community. - Member checking	*Boundaries & bridges to mental health support* *> Need for virtual mental health support* - Aggravated psychological & mental health challenges - Exacerbated access boundaries to in-person services *> Manifestations of technology-based boundaries* - Access to and use of equipment - Access to internet connections - Limited technology-based skills *> Virtual service bridges developed by the organization.* - Launching a phone support line - Creating various online programs - Training staff and ongoing support for peers - Enhancing social media presence *A sense of community in virtual mental health support* *>Strategies to maintain the sense of community:* - Maintaining continuous presence & social interaction - Establishing multiple points of connection - Building on organizational & peer culture - Acting collectively - Sharing lived experiences & learning together *> Implications beyond the pandemic* Hybrid model: Combining virtual and in-person mental health support services for enhanced accessibility.

Contributions to health care management and systems research

Synthesizing the research contributions across the Essays, this thesis enriches understanding of peer support role implementation in mental health systems and its transition to virtual space. It also offers insight into specific aspects of the lived experience of peers. Through a review of research, a fragmented literature was synthesized, offering a comprehensive understanding of the obstacles and enablers of PSW role implementation in mental health systems. This interpretive review provides a holistic view of influences on PSW role integration in mental health systems. The application of a multilevel framework helped uncover interlevel implications and identification of topics that remain under-researched, such as the role of gender. Examining the work-life boundary challenges for PSWs engaged in work-from-home settings provided an understanding of various types of boundaries that working from home entails, and of various boundary management strategies that workers can employ. These insights contribute to the literature on mental health workforce challenges and well-being. Furthermore, identifying technological factors as boundaries and bridges in mental health support contributes to the literature on virtual work and services and provides insight into establishing a sense of community in a virtual space. Highlighting the need for a hybrid model of peer support that combines in-person and virtual services is also a contribution that emphasizes the importance of increasing access to mental health support and reaching segments of the population that had been typically underserved. Last but not least, highlighting the experiences of peers contributes to the literature by valuing the perspectives of service users who are generally not the focus of attention in research.

Contributions specific to PSWs' role

This thesis makes significant contributions to the understanding of the PSW role. It underlines the importance of the PSW role within community mental health, showcasing PSWs' adaptability in response to evolving needs, particularly evident during the rapid transition to virtual services necessitated by the pandemic. Their non-regulated status enabled them to flexibly adapt to changing role expectations, particularly in integrating technology into their support services. However, this adaptability also marked the need for tailored training to equip PSWs for various service modalities and emphasized the importance of access to telecommunication equipment and Internet connectivity. The thesis also brings attention to the needs of the role, specifically training for different types of service provision modalities and the need for self-care as the well-being of PSWs has often been a neglected aspect of their work. Despite their vital role, PSWs frequently lack acknowledgment and support for their own well-being. The present study suggests that human resources policies that incorporate payment adjustments to address potential burnout, flexible employment contracts, and a community of practice can contribute significantly to promoting the well-being of PSWs. In addition, the thesis illuminates the precarious nature of the PSW role within the mental health care system, partly due to PSWs' ranking in the hierarchy of occupations in health systems, and also because funding is precarious and often regulatory and managerial/team support may be lacking. These findings collectively highlight the importance, yet vulnerability, of the PSW role, and the need for comprehensive support to the role within the mental health care system.

Implications for policy and practice: From an interdisciplinary perspective

The thesis points to a number of implications for policy and practice which could strengthen the PSW role and could help foster a more resilient and adaptable mental health care system.

The findings provide insights that can enhance policies related to the funding, recruitment, training, and retention of the community workforce. The articles collectively emphasize the significant role of policy in shaping the recognition and acceptance of the PSW role in mental health systems. Societal readiness and acceptance play pivotal roles in policy effectiveness, with policies aligned with cultural values more likely to succeed. Policymakers are encouraged to engage in discourse and education that highlights the social and economic value of peer support, thus legitimizing the role within professionalized and hierarchical systems. This approach can lead to increased allocation of resources to peer services in mental health, enabling organizations to plan for recruiting and retaining PSWs with formal contracts that value their contribution. Learning from successful cases and jurisdictions is recommended to inform policy decisions and enhance the incorporation of PSWs in mental health systems. In addition, the findings of the thesis indicate the importance of mobilizing policy commitment towards virtual work in the future of health human resources policies in health system – particularly, in policy areas relating to health workforce recruitment, training and retention. Additionally, policies may consider equitable access to technology resources not only for providers but also for service users, ensuring that underserved populations have access to devices and internet connections. As the overall findings of this thesis exhibited the importance of attention to the wellbeing of PSWs working in mental health support services, policies addressing the wellbeing of PSWs as well as other mental health support workers become relevant, notably, under circumstances where their work-life interface merge and they need to work from home.

From a practice standpoint, the thesis findings highlight the importance of informed managerial decision-making and human resources management at the organizational level. The findings showed that organizational and supervisory arrangements can facilitate the

implementation of the PSW role. Effective change management strategies that engage various stakeholders are essential for successful role implementation. Organizational leaders and supervisors could model stigma-free approaches and behaviours to improve workplace relationships and enhance the well-being of PSWs. In contexts where PSWs work with other mental health professionals, support from team members as well is deemed essential. Further, when implementing a hybrid model of combined virtual and in-person mental health support beyond the pandemic, PSWs would need attention from their managers to build capacity to enable them to overcome potential inhibiting factors relating to organizational and technological aspects. Additionally, the study provides valuable insights into work-life boundary management tactics for PSWs working from home, offering guidance on how to balance work and personal life effectively. Managerial strategies to ameliorate boundary challenges impacting PSWs role when working from home relate to PSWs' schedules, physical workspace and task intersections at home. Managers could support PSWs' well-being by providing training, self-care opportunities, flexibility of work schedule and supportive supervision. Moreover, maintaining a sense of community in virtual spaces, developing technology-related skills, and building the capacity to respond swiftly to crises are also practical considerations for peer support organizations.

Limitations and Directions for Future Research

This thesis has limitations that highlight implications for future research. The narrative review has limits to its methods. Despite rigorous efforts, the literature search likely did not capture all relevant articles. Further, the selection of key themes for the synthesis has an element of subjectivity, and by focusing on specific themes, we left out others, which could be the subject of future research. The empirical part of the thesis is based on a qualitative approach and the

findings are not generalizable at large. In addition, the work-life boundary and boundary management tactics were based on interview data collected during earlier stages of the COVID-19 pandemic. The empirical study does not attend to the evolving nature of challenges and opportunities experienced and the tactics applied by the PSWs over time. Therefore, longitudinal research is suggested to, first, capture these time-based limitations, and second, address the dynamics of reverse transitions to in-person services after the lockdowns. Further, the gender dynamics of work-from-home and work-life boundary management remained unexplored in this thesis. Future research could address this gap by investigating the gendered experiences of mental health support workers as well as how the experiences of the PSWs and service users were shaped by other intersecting identities –e.g., ethno-racial identities, income, and age. While technological boundaries and bridges were explored, concerns about privacy and social conflicts within virtual mental health support communities are left unexplored. Furthermore, the absence of peer support users who did not transition to virtual platforms poses a limitation, as factors contributing to their non-participation remain unclear. Future research could probe into the privacy and social boundaries associated with virtual peer support and investigate the experiences of those who stopped accessing peer support when it transitioned to virtual platforms.

Conclusion

This thesis has highlighted the importance of peer support as part of community mental health services. It has also highlighted the many challenges that peer support workers and organizations may face in the conduct of their work and potential solutions. I hope that this thesis provides useful information for policymakers, managers, peer support workers and peers, and that it is a stepping stone for future research on the critically important topic of peer support.

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APPENDICES

Interview Guides

Questions for the Peer Support Workers

Background Questions

We will start with a few background questions about your engagement with peer support services.

1. Can you tell me briefly about your background in providing peer support services?
2. How long have you been with PSO as a provider?
    - Have you been trained to provide peer support by PSO?

Experiences with Virtual Peer Support during the Pandemic

Thank you. Now, I'd like to turn to some questions about your experiences of providing virtual peer support and your experiences with the pandemic.

1. If I attended one of your typical peer support sessions during the pandemic, what would I see you doing?
2. What are the benefits of providing virtual peer support?
    - From your perspective, how did it help you and the service users during the pandemic?
3. What are the challenges that you faced delivering virtual peer support?
    - Regarding technology availability and knowhow, did you have any difficulties?
    - Make sure to probe here, e.g., about workspace at home.
4. How did you manage each of these challenges?
5. How has your role as a PSW been impacted because of virtual services?

6. Apart from the virtual services, how has your role as a PSW been impacted because of the pandemic?
7. How has virtual peer support impacted interactions? (between you and service users, among service users)
    - How has delivering virtual peer support changed your relationships with the service users?
8. Do you believe that the sense of peer support community has been impacted during the pandemic? If so, how?
9. How has virtual peer support impacted the boundaries that you maintain with service users?
10. How about the boundaries you maintain between personal and professional life?
11. Have you been able to maintain your own well-being during the pandemic?
    - (If yes): What are the factors that helped you maintain your well-being during the pandemic? (Probe about *supports* that were available **and** about *strategies* interviewee has used.) (If not): Can you tell me about your experiences?
12. Did you have access to a community of PSWs? How did this influence you?

Supports

13. Did you follow any training on virtual peer support? If so, what was this training?
    - In what ways was the training helpful or unhelpful?
14. (If not addressed before): What other supports were available?
15. What supports were missing?
16. What suggestions or recommendations do you have to managers and to policy makers regarding peer support during a pandemic? Let's start with managers.
    - What about suggestions or recommendations to policy makers?

Questions for the Peer Support Managers and Coordinators

Background Questions

We will start with a few background questions about your engagement with peer support services.

1. How long have you been with PSO and what are your current role and responsibilities?
2. Can you tell me briefly about your background as peer support manager/coordinator?
3. How do you work with other managers, coordinators or PSWs? In other words, how is your role defined in relation to others? How do you interact with others?
4. How does one become a manager (or coordinator) in PSO?
    - Does that involve any training? (if yes): can you tell me briefly about the training you received?

Experiences with Virtual Peer Support during the Pandemic

Thank you. Now, let's talk about your experiences with the virtual peer support during the pandemic.

1. How did the pandemic influence how you perform your role as manager (or coordinator)?
2. Can you describe the process of shifting from in-person to virtual form in the early stages of the pandemic?
3. What were the challenges?
    - How did you experience these changes?
    - What strategies did you adopt to minimize the challenges?
4. How did you prepare yourself and PSWs for virtual services?
5. Do you think that virtual services facilitated providing support to the service users? How?
    - Make sure to probe if there are new service users and why that is the case.

6. In your opinion, what are some opportunities associated with the pandemic?
    - Make sure to probe on the opportunities associated with virtual peer support
    - How do you think maintaining peer support virtually has helped the peer community during the pandemic?
7. Which of the changes you have made during the pandemic should be sustained and why?

Experiences with the Organizational Factors

Thank you. Now, I'd like to ask you about how contextual/organizational factors have influenced operations during the pandemic:

8. How do you think the culture of PSO as a peer support organization has influenced the shifts in work that have occurred due to the pandemic?
9. What measures has PSO adopted to help managers (or coordinators) during the pandemic?
    - Make sure to probe on e.g., training, and equipment for virtual work.
10. What are some of the strengths and weaknesses of the present team of managers, coordinators and PSWs that you think has impacted PSO's work during the pandemic?
    - Let's start with the strengths.
    - Make sure to probe on the skills and strategies of the team.
    - What are the weaknesses?
11. What suggestions or recommendations do you have to other managers of peer support and to policy makers regarding peer support during a pandemic?
    - Let's start with managers.
    - How about suggestions or recommendations to policy makers?

Questions for the Peer Support Service Users

Background Questions

We will start with a few background questions about your engagement with peer support services.

1. Can you tell me briefly about your background in receiving peer support services?
2. How long you have been attending peer support sessions, and have you been receiving one-on-one peer support or group peer support?

For service users who *did not continue* peer support during the pandemic

1. Can you explain the reasons behind not continuing to receive peer support after the transition to a virtual platform?
    - Make sure to probe about the preferences, concerns, confidentiality consideration, technical literacy, and perceptions of what effective peer support is.
2. How has not receiving peer support impacted you?
    - Make sure to probe about other supports or coping mechanisms

For service users who *have started* receiving peer support during the pandemic

1. Have you ever had the experience of receiving peer support before?
    - If not, what is it about the pandemic or virtual services that encouraged you to access these services?

For service users who *have continued* using peer support:

1. How have your experiences with peer support changed during the pandemic?
    - How do you compare your experience with the in-person services?

For service users who *have started or continued* using peer support:

2. Would you feel that you receive the support that you need through the virtual peer support sessions?
3. How would you describe your relationship with the PSWs in these virtual meetings?
    - How was it helpful for you?
    - Have you had any challenges in your relationships with the PSWs and if so, what are they?
4. What challenges did you have in accessing virtual peer support services?
5. Make sure to probe about the preferences, concerns, confidentiality consideration, technical literacy, and perceptions of what effective peer support is.
6. How would you describe your relationship with other service users in virtual meetings?
    - Have you had any challenges in your relationships with other service users and if so, what are they?
7. Do you believe that virtual services should be continued? If yes, why and if not, why not?
8. What issues would you like PSO to consider when designing services during the pandemic?
9. What issues would you like PSO to consider when designing services once the pandemic is over?
10. What other suggestions do you have?

Closing remarks for all interviews

Demographic Questions

Thank you. That was the last question, and now I have a few demographic questions.

1. How would you describe your gender identification?
2. Would you say your age is between 20-29, 30-39, 40-49, 50-59, 60-69, or over 70?

3. How would you describe your ethnicity?

Closing Questions

Thank you. Now there's a chance for us to make sure we haven't missed anything important in our discussion.

4. Is there anything you would like to add?
5. Is there anything I didn't ask that I should have asked?
6. If I have any other questions or need additional clarifications, is it ok for me to contact you again?

Closing Thanks

That was my last question. Thank you for your time and for participating in this interview. As a reminder, everything you've told me here will remain strictly confidential.

Consent Form for Individual Interview

Title of the study: Transition to virtual peer support during COVID-19: Impact on providers and users of peer support

Principal investigator: Elmira Mirbahaeddin, PhD candidate
Telfer School of Management, University of Ottawa
Email and phone number […]

Co-investigator: Samia Chreim, PhD
Telfer School of Management, University of Ottawa
Email and phone number […]

Invitation to Participate: I have been invited to participate in an individual interview for the abovementioned research study conducted by Elmira Mirbahaeddin and Samia Chreim from the Telfer School of Management, University of Ottawa.

Purpose of the Study: I understand that the purpose of this research is to explore how COVID-19 has impacted the roles and experiences of peer support workers (PSWs), service users, and peer support managers and it aims to investigate the strategies they have employed to deal with the challenges and the opportunities associated with the pandemic.

Participation: My participation will essentially consist of an individual interview lasting approximately 60 minutes which may be conducted remotely via videoconference, or a phone call. This interview will consist of answering questions related to my experience with peer support services during the COVID-19 pandemic. I agree to the session being recorded for better data collection purposes only. Upon my request, I will be given the opportunity to review my comments after the interview is transcribed and/or make changes to the information provided during the interview. If I want to receive a copy of the interview transcript in a password-

protected file, I will provide an e-mail address. I am aware that materials sent via email run the risk of being intercepted by a third party thus risking violating confidentiality.

Risks: My participation in this study will entail that I share personal information about mental health issues for which I seek peer support. This may cause me to feel psychological and emotional discomfort and could have negative social or personal implications if my anonymity were not sufficiently protected. I have received assurance from the researcher that every effort will be made to minimize these risks by ensuring that I have full control over the information I choose to share and by maintaining anonymity through disguising my name, my mental health condition, and any other identifiers. The researcher has also informed me that should I feel any distress due to sharing information on difficult experiences, I can receive support through the following services: Psychiatric Survivors of Ottawa Peer Support Call Back Service 613.567.4379x118; Mental Health Crisis Line 1.866.996.0991; Distress Centre 613.238.3311; Mood Disorders of Ontario (https://mooddisorders.ca/node/1240), Ontario Peer Development Institute (https://www.opdi.org/blog/how-to-access-remote-peer-support-during-covid-19/) and Robyn Priest's Live Your Truth (https://www.robynpriest.com/individual-2).

Benefits: My participation in this study will provide an opportunity to share my experience and perspective regarding peer support services during the COVID-19 pandemic. My participation will contribute to advancing knowledge on experiences of peer support during COVID-19, and will provide me with an opportunity to discuss and reflect on my experiences.

Confidentiality and anonymity: I have received the assurance from the researcher that the information I will share will remain anonymous. Only the researchers and their research assistants will have access to the interview data. I understand that the data collected will be used

only for the above project and that my name will not be disclosed when presenting the results of the research**.** While the published research may include quotes from the interview transcript, in the event of any such quotes, all information concerning the identity of the participants will be disguised.

Conservation of data: The data collected (audio recording of interview, interview transcript, handwritten notes and other relevant documents) will be kept in a secure manner. Electronic files will be stored on a computer with a secure password and paper copies will be in a locked cabinet. The data will be kept for 5 years and destroyed securely thereafter.

Voluntary participation: I am under no obligation to participate and if I choose to participate, I may withdraw from the study at any time and/or refuse to answer one or more questions without suffering any penalties. If I choose to withdraw, I will keep full compensation amount and all data gathered until the time of withdrawal will be destroyed.

Acceptance: I, _____ _, agree to participate in the above study conducted by Elmira Mirbahaeddin and Samia Chreim of the Telfer School of Management at the University of Ottawa. As a token of appreciation, I received a $25 cash (direct deposit or gift card) from the researcher team. If I have any questions about the study, I may contact the researchers. If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON, K1N 6N5, Tel.: (613) 562-5387 or Email: ethics@uottawa.ca. There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____ ***Date:*** _____

Researcher's signature: _____ _____ ***Date:*** _____