

The Role of Peer Support Providers in Inter-Professional Mental Health Care Teams

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Abstract

This qualitative study explores construction of peer support providers' roles within inter-professional mental health care teams. The study focuses on factors influencing peer support providers' integration; implications of such integration to stakeholders; and views on introducing peer support certification. Interviews were conducted with peer support providers in two formal models of peer support employment in health care organizations in Ontario. Grounded theory approach was used to analyze data. The findings point to a variety of factors that enable peer support providers' integration as well as the challenges that they face in role construction. Implications of role integration suggested multiple benefits to various stakeholders. Participants were generally supportive of certification, but called for more research on this subject. Findings may be transferable to other formal peer models given similar contexts. Understanding of role construction and factors influencing integration may benefit peer support providers and health care organizations about to integrate the role.

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1. Introduction

1.1. Background

The closure of asylums and the scaling back of in-patient services provided by mental health institutions in the 1960s in North America increased the need for community mental health programs (Adame & Leitner, 2008, p. 150; Everett, 2000, p. 38-39) and triggered the development of independent peer service provider programs. Despite these developments, there is a view that Canada has been slow in reforming and incorporating peer support in the mental health care system (The Standing Senate Committee on Social Affairs, Science and Technology, 2006). A general definition of peer support in mental health is “any organised support provided by and for people with mental health problems” (O’Hagan, Cyr, McKee & Priest, 2010, p. 42). Individuals who provide peer support are often referred to as peer support workers or peer support providers (O’Hagan et al., 2010).

In the mental health care field, there has been increased attention to and use of holistic recovery-oriented approaches. This change has been noted and encouraged in a variety of provincial and national reports, including: *The time is now: Themes and recommendations from mental health reform in Ontario* (Provincial Forum of Mental Health Implementation Task Force Chairs, 2002); *Out of the shadows at last* (Standing Senate Committee on Social Affairs, Science and Technology, 2006); and *Respect, recovery, resilience: Recommendations for Ontario’s mental health and addictions strategy* (Minister of Health and Long-Term Care’s Advisory group, 2010). The recovery-oriented community model is more focused on including the consumer’s voice regarding treatment options, as well as looking at the management of illness to promote independent living and functioning (Stotland, Mattson & Bergeson, 2008; Silverstein & Bellack, 2008). This model of care stresses the need for peer support as a component of the recovery process (Adame & Leitner, 2008; Davidson, Chinman, Sells & Rowe, 2006; Mead, Hilton & Curtis, 2001).

Peer support in mental health has become an opportunity for individuals who have recovered from mental illnesses to perform meaningful work while contributing their perspective of mental health care delivery (Moll, Holmes, Geronimo & Sherman, 2009). One area of mental health that has made considerable progress in integrating peers into the

team of providers is Assertive Community Treatment (ACT) teams. Peer specialists, as they are known in ACT teams, are individuals who provide “expertise that professional training cannot replicate”; they also “provide highly individualized services and promote client self-determination and decision-making” (MOHLTC, 2005). Beyond ACT, there has been a movement to integrate peer support in mental health care provision in a variety of teams. There has also been increased government funding of independent peer run initiatives (O’Hagan et al., 2010, p. 50), and the introduction of peer support programs in mental health institutions (Woodhouse & Vincent, 2006).

Due to peer support workers’ unique consumer/client perspective, they are able to engage in the recovery planning and assistance of clients in a way that other health care professionals would not be able to do (Campbell & Leaver, 2003). Their role and duty may include: facilitating group programs, providing individual support to patients, and advocating patient’s voice in treatment (Chinman, Weingarten, Stayner & Davidson, 2001; Jacobson, Trojanowski & Dewa, 2012; Moll et al., 2009). Benefits of peer support include the provision of holistic care (Mead et al., 2001), the ability to reach vulnerable, hard to reach populations (Campbell & Leaver, 2003) and the ability to change perception of stigma (Solomon, 2004).

Despite the benefits connected to peer support providers, there are also many difficulties associated with their integration in teams. Barriers to collaboration have often included power struggles between professionals, ambiguity around roles, and conflict due to varying approaches to health and treatment (Keith & Askin, 2008; Rose, 2011). Obstacles specifically faced by peer support workers who provide services alongside other health care professionals in mental health institutions often include: role ambiguity (Moll et al., 2009; Repper & Carter, 2011; Gates & Akabas, 2007), limited hours of work (Moll et al., 2009; Miyamoto & Sono, 2012), and stigma (Chinman, Lucksted, Gresen, Davis, Losonczy, Sussner & Martone, 2008). The implementation of certification of peer support workers has been a recent development in North America and has been perceived as a positive development by the Mental Health Commission of Canada (MHCC, 2013, p. 19).

Several programs have been created in the United States for certification of peer support workers, and in Canada there are plans for implementing a national program currently under consideration. The Mental Health Commission of Canada sees the certification of peer support workers as a positive development for their integration within mental health teams (MHCC, 2013, p. 19). Certification, however, has not yet been investigated from peer support providers' perspectives to find out more about whether it is an obstacle or enabler to collaboration.

The contributions of existing literature regarding integration of peer support workers within inter-professional health care teams are limited to understanding the role and duties of peer-support providers (Miyamoto & Sono, 2012; Repper & Carter, 2011). There is a need to better understand how peer support providers integrate within inter-professional mental health care teams; how their roles are constructed; what factors influence their integration and subsequent work within teams; and what they contribute through their work on these teams. Given recent developments in peer support certification, there is also a need to understand how this change will affect the role integration of peer support workers in mental health teams.

1.2. Research Objectives

The purpose of this qualitative study is to generate an understanding of peer support providers' views of their role definition and integration in inter-professional mental health care teams. More specifically, the study focuses on peer support providers' views of:

- 1) A. How their roles are defined and constructed in inter-professional mental health teams
B. The factors that influence their integration and subsequent work within teams
- 2) The contribution and implications of such integration to the clients, the team, and the peer support providers themselves
- 3) The implications of introducing peer support certifications.

2. Literature Review

In this section, I present an overview of the literature on recovery, peer support definition, benefits and models, role of peer support providers in the mental health system, and I conclude by summarizing the gaps in the literature.

2.1. Peer Support in Mental Health

2.1.1. Definition of recovery.

The notion of recovery has received increasing attention in health care, especially in the mental health care sector. Nevertheless, in Canada it has been difficult to obtain a consensus on the definition of recovery or on how recovery impacts the service delivery of mental health (Piat, Sabetti, Couture, Sylvestre, Provencher, Botschner & Stayner, 2009). In order to better understand the concept of peer support, it is necessary to recognize and understand recovery as a holistic process that encompasses multiple variables of health. Table 1 illustrates several elements of recovery derived from an ecological framework by Onken, Craig, Ridgway, Ralph, and Cook (2007) and built upon by a study on the perspectives of Canadian mental health consumers conducted by Piat et al. (2009). Onken et al.'s framework presents recovery as a “multidimensional, fluid, non-sequential, complex” process (2007, p. 10). Piat et al. (2009) used this framework as a foundation for additional perspectives and definitions of recovery from literature and from mental health consumers in Quebec and Ontario. Table 1 highlights the findings from the two studies by dividing them into two major categories: recovery in relation to wellness and in relation to illness. The illness category is a traditional model perspective while the wellness category focuses on the rehabilitation aspect of recovery. My thesis will focus on the wellness category as it identifies peer support as a component of the recovery process as an exchange and community-centered element.

Table 1: The Elements of Recovery [Adapted from study by Piat et al. (2009) and Onken et al. (2007)]

Recovery in relation to:	
Wellness	
Person-Centered and Re-authoring Elements of Recovery	
1	Hope, acceptance and engagement (Ridgway, 2001).
2	Self-determination and shared decision making (Deegan, 2007; Deegan & Drake, 2006; Frese & Davis, 1997; Schauer, Everett & del Vecchio, 2007)
3	Empowerment: “Consumer-survivors emphasize resourcefulness and resilience as the basis of recovery” (Piat et al., 2009). Recovery “means taking charge of life” (Piat et al., 2009).
4	Re-formulated identity: Re-negotiation of identity that “has been shattered by mental illness” (Piat et al., 2009). Recovery “means evolving toward a new self” (Piat et al., 2009).
Exchange and Community-Centered Elements of Recovery:	
1	Connectedness (Ahern & Fisher, 2001; Frese & Davis, 1997)
2	Supportive psychiatric relationships (McGrath & Jarrett, 2004)
3	Peer Support (Solomon, 2004)
4	Elements of recovery promote “firm sense of agency, purpose, and meaningfulness built upon an integrated and positive understanding of self” (Onken et al., 2007, p. 15).
Illness	
Clinical Recovery	
1	Recovery means a cure, dependence on medication and returning to former self (Piat et al., 2009).

A key element of the recovery oriented model is attention to the importance of the individual consumer’s psychological, social, and economic context; as well as recognition of the importance of the consumer’s voice in their treatment options (Silverstein & Bellack, 2008). These aspects of care are often not included in the medical model, which attempts to diminish the importance of alternative treatments, while enforcing a singular view of treatment options (Davidson & Strauss, 1995; Adame & Leitner, 2008). In the medical model, interventions are targeted towards biological and cognitive processes to fix the pathological trigger behind the symptoms (Adame & Leitner, 2008, p. 147). Additionally in this model, opposition to medical authority or an alternative view of treatment is often seen as “ignorant, misinformed” or it is argued that the “patient lacks insight into the reality of his or her disease” (Adame & Leitner, 2008, p. 147). The recovery-oriented model, in contrast, is more focused on including the consumer’s voice regarding treatment options; as well as looking at the management of illness to promote independent living and functioning (Stotland et al., 2008; Silverstein & Bellack, 2008). This model of care stresses the contribution of peer support as a component of the recovery process (Adame & Leitner, 2008; Davidson et al., 2006; Mead et al., 2001).

2.1.2. Definition of peer support.

Peer support has been defined in various ways. The most general understanding, as presented by the Peer Support Project Committee of the Mental Health Commission of Canada, is “any organised support provided by and for people with mental health problems” (O’Hagan et al., 2010, p. 42). Although peer support may include both formal and informal services offered through various peer support frameworks, organised peer support in the above report was referred to as ‘peer initiatives’ which included peer support provided through “programs, networks, agencies or services” (O’Hagan et al., 2010, p. 42). Other definitions of peer support in the literature are presented in Table 2.

Table 2: Varying Definitions of Peer Support in Literature

Study/Article Author	Definition
Mead, Hilton & Curtis, 2001	“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. <i>Peer support is not based on psychiatric models and diagnostic criteria.</i> It is about understanding another’s situation empathically through the shared experience of emotional and psychological pain... without the constraints of traditional (expert/patient) relationships.”(2001, p. 135).
Gartner & Riessman, 1982 & Solomon, 2004	Peer support is “social emotional support, frequently coupled with instrumental support” (Gartner & Riessman, 1982 in Solomon, 2004, p. 4). Peer support groups, such as self-help groups, “are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bringing about desired social and/or personal change” (Gartner & Riessman, 1982, p. 631).
Davidson, Chinman, Sells & Rowe, 2006	Peer support is service provided by individuals who have a past history of mental illness and are currently experiencing significant improvement in their psychiatric condition. The service recipients are individuals who have not reached very far in their recovery path. The authors differentiate peer support from “ <i>traditional self-help, mutual support groups... and consumer-run drop-in centres</i> ” (2006, p. 444).
Adame & Leitner, 2008	“Peer support is typically characterized by its mutual, non-hierarchical mode of being with other people who have had struggles similar to one’s own...People who have been harmed by or are dissatisfied with the mental health system may choose peer support as an <i>alternative to traditional psychotherapy or psychiatric interventions</i> ” (2008, p. 148)

The philosophy of peer support is consistent with the recovery approach to mental health. Although peer support encourages the reduction of symptomology, the main focus is

on improving quality of life and engagement of clients in their recovery process towards wellness (MHCC, 2013, p. 12). Peer support has existed for well over a century, and in the mid 1800s, the first peer support establishment for the mentally ill was opened in England (Peterson, 1982, p. 93; O'Hagan et al., 2010). The initiation of such groups, and the reform of mental health during the 1900s, was primarily due to the ill treatment of patients with mental illnesses (O'Hagan et al., 2010). The most prominent example of an established peer support network in North America is the Alcoholics Anonymous, which was first initiated in the 1930s using a step-by-step program (O'Hagan et al., 2010). This program was then transferred and adapted to other aspects of health care, including drug abuse and mental health illness. It was looked into further during the de-institutionalization of asylums and mental health institutions in North America throughout the 1960s (Adame & Leitner, 2008, p. 150). The de-institutionalization led individuals from these institutions to be located in the community, which consequently increased the emphasis on community mental health programs (Adame & Leitner, 2008; Everett, 2000, p. 38-39). In the 1970s, the first Canadian mental health community peer support service was initiated in Vancouver, titled the Mental Patients Association (O'Hagan et al., 2010). This service precipitated the development of independent peer service providers around the country, with Ontario achieving significant developments (Everett, 2000, p. 39). Peer support has since been implemented in various areas of health, including the care for individuals with chronic illnesses and trauma such as spinal cord injury (Haas, Price & Freeman, 2013), cancer (Hanson, Armstrong, Green, Hayes, Peacock, Elliot-Bynum, Goldmon, Corbie-Smith & Earp, 2012; Cheng, Sit, Chan, So, Choi & Cheng, 2013), burns (Badger & Royse, 2010) and diabetes (Riddell, Renwick, Wolfe, Colgan, Dunbar, Hagger, Absetz & Oldenburg, 2012).

In relation to peer support implementation in mental health, in 1991, the Ontario Ministry of Health and Long Term Care proposed the funding of consumer run initiatives (CSI) (Janzen, Nelson, Hausfather & Ochocka, 2007). This initiative was titled "The Consumer/Survivor Development Initiative", with approximately \$3.1 million of funding (Janzen et al., 2007). Eventually the initiative was retitled "The Ontario Peer Development Initiative (ODPI)", and grew to include approximately 60 plus programs run in Ontario with the help of \$5 million funding dollars (Janzen et al., 2007). The goals adopted by the CSI

were customized to meet the needs of particular communities. Over time, the development of these CSIs has led to their integration in health care institutions (e.g. hospitals) and community-based programs (e.g. Assertive Community Treatment Teams) (Janzen et al., 2007).

Implementation of peer support initiatives has gained attention from the Canadian government due to prominent benefits reported at multiple levels of the mental health care system. In 2010, the Mental Health Commission of Canada (MHCC), a non-profit organization created and funded by Health Canada, released a report, *Making the case for peer support*, that provided an overview of the literature on peer support in mental health and presented input from Canadian peer support workers and clients from across Canada (O'Hagan et al., 2010). In addition to this report, the MHCC also conducted consultations with peer support workers, surveys and focus groups across Canada for a Peer Project (MHCC, 2013, p. 7). This project resulted in the creation of a collective voice emphasizing the need for peer support as a component of mental health (MHCC, 2013, p. 7).

As a result of the Peer Project, a not-for-profit Peer Support Accreditation and Certification Canada (PSACC) organization was created in 2011 (PSACC, 2012). This organization was developed to standardize aspects of peer support delivery nationally, while opening an opportunity to provide certification and accreditation to peer support workers on a voluntary basis (PSACC, 2012). This organization will rely on evidence-based practice data to evaluate outcomes of peer support at the individual, organizational, and systems level (PSACC, 2012).

2.1.3. Evidence of benefits.

Several qualitative and quantitative studies have reported benefits associated with peer support. Benefits have been documented at multiple levels in the mental health care system, namely the individual, organizational, policy/governmental, and societal level (Janzen et al., 2007).

2.1.3.1. Individual level benefits.

There are benefits to peer support at the individual level of client, peer support worker, and health care professionals.

A. Client benefits.

Client clinical outcomes have been key indicators for the adoption of peer support practices in the mental health care system. Empirical data suggests that peer support workers provide comparable or improved services to those of health care professionals regarding counselling (Cook, 2011). Prominent benefits to the client have included:

i. Empowerment of clients, sense of hope, and increased quality of life

Peer support providers are often seen as role models of recovery (Lawn, Smith & Hunter, 2008; Rabenschlag, Hoffmann, Conca & Schusterschitz, 2012). This perception of peer support providers often represents an optimistic outlook for the future and gives hope for a possible recovery (Lawn et al., 2008; Rabenschlag et al., 2012). Additionally, studies looking at the service user view indicate that peer support encourages individuals to move from a traditional role of a client or patient in mental health to a more active role involving voicing of opinions (Ochocka, Nelson, Janzen and Trainor, 2006; Repper & Carter, 2011). Bean, Shafer and Glennon, examined the impact of peer support on individuals who are medically vulnerable and homeless and found that peer support improved clinical outcomes (2013). These clinical outcomes include significant increases to access and utilization of health care services, improved quality of life, and decreased involvement with the criminal justice system over a period of 12 months (Bean et al., 2013). Similarly, an earlier study by Felton, Stastny, Shern, Blanch, Donahue, Knight, and Brown compared intensive case management teams with and without peer specialists (1995). The study revealed that the teams with peer specialists “demonstrated greater gains in several areas of quality of life and overall reduction in the number of major life problems experienced” (Felton et al., 1995, p. 1037).

ii. Reduction in hospital re-admission rates

Randomized control trial studies examining the effectiveness of peer support intervention in addition to routine care indicated that no significant differences were present in admission rates or length of stay (Repper and Carter, 2011; Solomon and Draine, 1995; O'Donnell, Parker & Proberts, 1999). Other studies looking at peer support interventions in out- and in-patient units showed earlier discharge among clients receiving peer support services in addition to regular care (Forchuk, Martin, Chan & Jensen, 2005; Repper and Carter, 2011, p.396). A study by Chinman et al. (2001) found a substantial 50% reduction of outpatient re-hospitalization of clients receiving peer support (Repper and Carter, 2011), which was similar to the findings from Min, Whitecraft, Rothbard and Slazer (2007), who did a study on consumer-delivered peer support program.

iii. Reducing stigma

An important outcome associated with peer support intervention has been the reduction of stigma, especially with regards to the self-stigmatization of clients with mental illness. A study by Ochocka et al., regarding consumer-initiatives across Ontario, found that clients using peer support services were less likely to see stigma as a barrier to finding employment and remained more hopeful of recovery (2006). Peer support workers have been able to combat the stigma of mental illness by acting as role models for recovery. In doing so, peer support providers educate not only clients, but also other health care staff members about the hope of recovery and the ability for clients to have a satisfactory lifestyle (Mowbray, Moxley & Collins, 1998; Lawn et al., 2008, p. 502). A study by Verhaeghe, Bracke and Bruynooghe (2008) looked at over 500 clients of rehabilitation services and suggested that receiving peer support decreases self-stigmatization. Also, a cross-sectional study that looked at the quality of life of clients with mental illness in a Chicago mutual help program emphasized the positive impact of peer support in decreasing self-stigmatization (Corrigan, Sokol & Rüsck, 2013).

iv. Social support and functioning

In addition to the benefits reported above, peer support is recognized as providing gains in social support and functioning for clients. In studies of peer support in mutual help

groups, an increase in use of community resources and social support network was noticed along with a decreased need for social assistance (Castelein, Bruggeman, van Busschbach, van der, Gaag, Stant, Kneegtering & Wiersma, 2008).

B. Peer support worker benefits.

As well as the advantages for clients, there are significant benefits acknowledged in the literature for the peer support providers themselves. Provision of peer support can be, in itself, a form of therapeutic experience due to the active process of listening and engaging with the client or consumer. This ‘helper-therapy’ principle has been observed in multiple studies (Salzer & Shear, 2002). Reported benefits have included: ‘personal growth’ from exchange of stories with clients; ‘increased self-acceptance and self-concept’ through the discovery of commonalities with clients along with the development of a positive self-image; increased social network and sense of connectedness with other peer providers; feeling ‘empowered’ by the ability to advocate peer support and to create change in the current mental health system; and development of transferable work skills in addition to preparing oneself for future employment opportunities (Hutchinson et al., 2006; Salzer et al., 2013; Mowbray et al., 1998; Besio & Mahler, 1993).

C. Health care professional benefits.

In addition to benefits for the clients and peer support providers, advantages have been observed for health care professional and staff members. Peer support providers often work with other professionals to promote or advocate for client needs and these interactions can influence how health care professionals perceive and benefit from their own service delivery (Jacobson et al., 2012, p. 8).

Studies looking at feedback from health care professionals working alongside peer providers have revealed that peer support providers were important in communicating information about mental health services (Lawn et al., 2008, p. 505). The peers’ position as a liaison for the client assisted health care professionals in obtaining a better understanding of client needs (Lawn et al., 2008; Davidson, Bellamy, Guy, and Miller, 2012). Additionally, peer support providers are examples and often role models of recovery for both health care

professionals and consumers (Jacobson et al., 2012). Interactions between staff members and peer support providers promote recognition of peer roles as “examples to staff looking for a new way in which to work” (Jacobson et al., 2012, p. 8).

2.1.3.2. Organizational level benefits.

The organizational level may include health care institutions such as hospitals and community-based health centers (Janzen et al., 2007). Hospitals have been in the system from the beginning, but community-based programs have only been steadily integrated in recent years (CMHEI, 2004). The increased integration is promoted by positive outcomes, which indicate that community-based services assist clients in recovering, while simultaneously integrating them back in the community to live a much more fulfilling life (CMHEI, 2004, p. 5). Examples of community-based programs are Assertive Community Treatment (ACT) and Intensive Case Management (ICM) (CMHEI, 2004, p. 5). Many of these community-based programs have integrated peer support components. For example, ACT teams are mandated to have a peer specialist who provides services to clients (MOLTC, 2005). In hospitals and similar institutions, peer support can be found either as a separate program or as part of in-patient inter-disciplinary teams.

The integration of peer support in hospital and community-based organizations has been shown to provide benefits at the organizational level such as the ability to represent the consumer-survivor perspective and to influence various service areas within an institution. Recognizing the voice of the consumer provides a better understanding of client needs and also empowers the clients to speak about their illness and the recovery process (Mead & Copeland, 2000). The presence of peer support within health care organizations greatly affects the overall sensitivity and skills of non-consumer staff by exposure to consumer staff treatment insights (Besio and Mahler, 1993; Carlson, Rapp & McDiarmid, 2001; Chinman et al., 2008). Additionally, the services provided by peer support providers assists in integrating the recovery-oriented care elements within the organization (Frost et al., 2011; Jacobson et al., 2012; Mead & Copeland, 2000; Salzer, 2002). By engaging consumers’ perspective in program planning and providing insight on alternative treatments, elements of recovery-oriented care are implemented in more traditional-oriented health care organizations. The

introduction of peer support has pushed organizations to provide consumer advocacy councils and participation in consumer initiative programs (Janzen, Nelson, Trainor & Ochocka, 2006).

2.1.3.3. Policy and government level benefits.

Government agencies develop and adjust policies related to peer support in mental health settings (Janzen et al., 2007). Government stakeholders concerned with the mental health system are found at the municipal, provincial, and federal levels. Government level changes include the representation of consumer voices in hearings and legislations. An example of this inclusion can be observed at the provincial level regarding Bill 68 (Mental Health Legislative Reform) – Brian’s Law of Community Treatment Orders (CTOs) (Janzen et al., 2006). Although the peer support community was unable to prevent the bill from passing into law, Parliament and the health care community were able to recognize that this bill was a concern among peer support providers (Janzen et al., 2006, p. 295). The peer community was able to present their views regarding the absence of the client voice in the treatment process. In addition to lobbying for the rights of the clients, the peer support community lobbies for funding to be directed towards programs that the community members need (Janzen et al., 2007).

2.1.3.4. Society level benefits.

The societal level is composed of the general public, media, and educational institutions (Janzen et al., 2007). This level is often concerned with the general perception of mental illness, and how this perception changes over time. It has been recognized that the meaning of health and treatment changes over time. The most visible effect of peer support provision was the modification of services to make them more relevant in meeting client needs (Besio and Mahler, 1993; Chinman et al., 2008). As discussed earlier, clients benefited overall with improvement in their mental health and quality of life. Additionally, there were benefits reflected in earlier discharge of clients. Furthermore, peer support providers are excellent sources of expert human resources in environments where limited skilled workers are available (Besio and Mahler, 1993; Solomon, 2004). They are able to navigate the system more effectively with their personal experience and are able to offer a mixed role of

peer and staff enabling connections between staff and clients (Besio and Mahler, 1993; Solomon, 2004).

A benefit of peer support at the societal level has been to increase general awareness of mental health and the importance of recovery. Nelson, Ochocka, Janzen, and Trainor indicate that educating the public about mental health issues and reaching out to the general public to raise awareness of the need to change the perception of stigma are benefits that can be introduced by peer support (2006). This type of change in society often takes a long time, mainly because the change needs to happen at many levels of the mental health system.

2.1.3.5. Summary of benefits.

A summary of the benefits at different levels is provided in Table 3.

Table 3: Summary of peer support benefits at the different mental health system levels

Individual Benefits for:		
Clients		
1	Empowerment of clients and sense of hope	Lawn, Smith & Hunter (2008) Rabenschlag, Hoffmann, Conca & Schusterschitz (2012) Ochocka, Nelson, Janzen, & Trainor (2006) Repper & Carter (2011)
2	Increased quality of life	Bean, Shafer, & Glennon (2013) Felton, Stastny, Shern, Blanch, Donahue, Knight, & Brown (1995)
3	Reduction in hospital re-admission rates	Repper & Carter (2011); Solomon & Draine (1995) O'Donnell, Parker & Proberts (1999) Forchuck, Martin, Chan, & Jensen (2005) Chinman, Weingarten, Stayner, & Davidson (2001) Min, Whitecraft, Rothbard, & Slazer (2007)
4	Reducing stigma	Davidson, Chinman, Sells & Rowe (2006) Ochocka, Nelson, Janzen, & Trainor (2006) Moxbray, Moxley, & Collins (1998)
	Reducing self-stigmatization	Verhaeghe, Bracke, & Bruynooghe (2008) Corrigan, Sokol, & Rusch (2013)
5	Social support and functioning	Castelein, Bruggeman, van Busschbach, van der Gaag, Stant, Kneegtering, & Wiersma (2008)
Peer support workers		
1	Individual empowerment and improved understanding of mental health	Salzer and Shear (2002) Moran, Russinova, Vasudha, Yi, & Sprague (2012)
2	Development of hope and strengthening of social networks	Moran, Russinova, Vasudha, Yi, & Sprague (2012)
3	Skills development	Mowbray, Moxley, & Collins (1998)
Health care professionals		
1	Improved understanding of clients' needs	Lawn, Smith & Hunter (2008) Davidson, Bellamy, Guy, & Miller (2012)

	2	Focus on recovery-oriented care	Jacobson, Trojanowsky, & Drew (2012)
Organizational Benefits:			
	1	Representation of the consumer-survivor	Mead & Copeland (2000) Janzen, Nelson, Trainor, & Ochocka (2006)
	2	Positive influence on other service sectors	Janzen, Nelson, Trainor, & Ochocka (2006) Frost, Heinz, & Bach (2011); Besio and Mahler (1993)
	3	Encouraging discussion of peer support practices	Jacobson, Trojanowsky, & Drew (2012) Mead & Copeland (2000); Salzer (2002)
	4	Integrating elements of recovery-oriented services	Carlson, Rapp & McDiarmid (2001) Chinman, Lucksted, Gresen, Davis, Losonczy, Sussner, & Martone (2008)
Policy/Government Benefits:			
	1	Focus on recovery-oriented services	Janzen, Nelson, Hausfather, & Ochocka (2007)
	2	Lobby for community needs	Janzen, Nelson, Trainor, & Ochocka (2006)
Societal Benefits:			
	1	Educating staff & public about mental health issues	Nelson, Ochocka, Janzen, & Trainor (2006) Chinman, Lucksted, Gresen, Davis, Losonczy, Sussner, & Martone (2008)
	2	Raising awareness about stigma	Besio and Mahler (1993); Solomon (2004) Chinman, Lucksted, Gresen, Davis, Losonczy, Sussner, & Martone (2008)
	3	Source of expert human resource	Besio and Mahler, 1993; Solomon, 2004

2.1.4. Models of peer support employment.

Peer support follows different service models. These models are often categorized based on the formality of their service delivery. In existing literature, models are often classified as either formal or informal. Davidson, Chinman, Sells, and Rowe provide a continuum with different types of models and explanations about the level of reciprocity between clients and peer support providers who exchange personal experiences (2006). Figure 1 is an example of a continuum, adapted from both The Peer Support Accreditation and Certification Canada (PSACC) and Davidson et al. (2006), to provide a visual perspective on the differences between formal and informal peer support employment models.

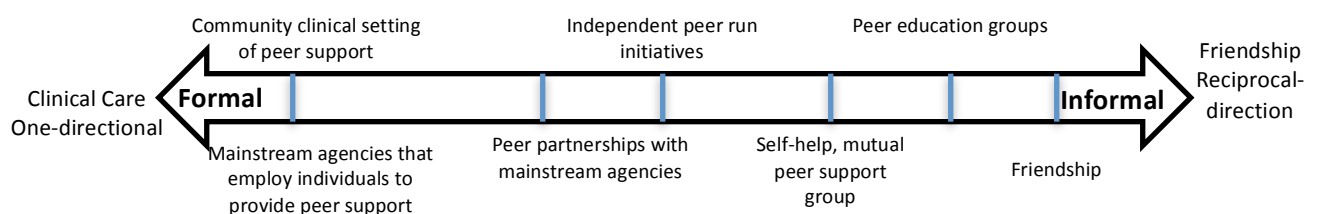


Figure 1: Continuum of the types of peer support

Models vary according to the type of service delivered and the requirements to provide the service. Using a framework outlined by Woodhouse and Vincent (2006) with a breakdown proposed by the Mental Health Peer Support Project Committee (O'Hagan et al.,

2010), an outline of the various forms of peer support available in the field of mental health is provided in Appendix 8.1. The continuum is used to demonstrate the differences in peer support approaches. Whereas some approaches are highly structured or standardized (e.g. formal models such as ACT), others are flexible, allowing for individual input in order to facilitate programs (e.g. informal models).

Informal models of peer support have been present in Canada since the early 1970s, whereas formal integration of peer support services into the health care organizations is a much more recent trend. Davidson et al. (2006) identified that formal models lack reciprocity and the ability to foster naturally occurring support relationships because of the peer support provider status as paid employee of the organization. Moreover, while peer support providers' focus is to maintain confidentiality about their engagement with clients, it is difficult to do so when the health care organizations require peer support providers to follow set standards of confidentiality, which may involve sharing information about client with team members (Davidson et al., 2006). Formal models of peer support may introduce tensions in boundaries with clients because providers may be unable to reciprocate feelings of friendship (Davidson et al., 2006). Despite these differences, there have been positive benefits reported from the formal models including a positive attitude towards medication compliance (Solomon & Draine, 1995) and enhanced access to social opportunities for participation (Jewell, Davidson, & Rowe, 2006), in addition to the benefits listed in Table 3.

This thesis will focus on formal models of peer support employment since these arrangements provide more insight into the interactions between peer support workers and health care professionals when compared with informal models where peers function individually and their interactions with other health care providers are minimal. The two types of peer support models that will be studied within the formal setting will include: Assertive Community Treatment Teams (ACTT) and non-ACTT models. These models of peer support employ inter-professional collaboration at varying levels.

The general category of mainstream agencies employing peer support providers (e.g. ACTT and non-ACTT) encompasses any peer support worker employed by mainstream

agencies as a member of a multi-, inter-, or trans-disciplinary mental health team within the hospital or community. In the literature, peer support members within teams often have varying levels of responsibilities and duties due to the lack of standardization and variable work environments (Miyamoto & Sono, 2012). There are two clear models of peer support provision in mental health organizations, the first being ACTT. This model employs a peer support provider as a member of a community-based team, aimed to support individuals with mental illness living in the community (CMHEI, 2004). In order to reduce hospital contact for individuals with mental illness, community-based programs treat or provide resources to clients in the community at varying levels (CMHEI, 2004). In ACT teams, peer support workers are identified as ‘peer specialists’ who provide highly individualized services to clients and promote client self-determination and decision-making” (MOHLTC, 2005). ACT team members provide highly integrated services to meet the clients’ needs (Bond, Drake, Mueser & Latimer, 2001). These services are available 24/7 through teams composed of a variety of health care professionals and service specialists including nurses, psychiatrists, occupational therapists, and social workers in addition to peer specialists (MOHLTC, 2005).

The Ontario ACTT Program Standards (MOHLTC, 2005) indicate that peer specialists:

...provide highly individualized services and promote client self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each client’s point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities (p. 15).

The second type of model employing peer support providers in formal organizations is non-ACTT. These peer support providers work in hospitals or health care settings but unlike ACTT peer specialists, their roles are not prescribed by standards. Peer support providers in non-ACTT models are only required to follow their health care organizations requirements. Examples of peer support providers as members of a team within these settings include:

- Peer support providers in support housing and rehabilitation services (Moll et al., 2009)
- Peer support providers on mental health teams in social service agencies (Gates & Akabas, 2007).
- Peer support providers in psychiatric emergency rooms (Griswold, Pastore, Homish & Henke, 2010).

For the purpose of this study, ACTT and non-ACTT models of peer support employment were used for participant recruitment. All non-ACTT programs employing peer support providers in formal settings were grouped as one participant pool.

2.2. Factors Influencing Peer Support Provider Integration in Mental Health Teams

The largest enabler to peer support provider integration within teams is the support of government and health care organizations. In an effort to support services that match the goal of the government, many mental health organizations have been mandated to integrate peer support providers onto teams (e.g. ACT teams) through Program Standards (e.g. ACT Program Standards). Mental health organizations are also moving towards the integration of peer support services as they listen to the voice of consumers and recognize that it will enable them to come to a better understanding of clients' needs, (Mead & Copeland, 2000).

Although multiple studies have demonstrated the clinical benefits of having peer support provider services, it still remains difficult for organizations to integrate their role (Gates & Akabas, 2007). The literature points to several challenges associated with peer support provider integration. These include:

- Perception of stigma from health care professionals and staff members: A review by Davidson et al. (2012) analyzed common questions asked by health care professionals and staff members. Many of these questions represented a perception of peer support providers as fragile individuals, who would be unable to meet the demands of their job (Davidson et al., 2012). Due to the stigma associated with mental illness, health care professionals and staff members are reluctant to engage with peer support providers.

- Inadequate training and role ambiguity: In some studies, inadequate training was noted as a barrier for peer support providers in service provision (Moran, Russinova, Gidugu, & Gagne, 2013; Gates & Akabas, 2007). Due to insufficient training and the lack of role standardization, peer support providers often experience ambiguity regarding the parameters of their role (Solomon & Draine, 1996). This role ambiguity includes difficulties in understanding what responsibilities are associated with the peer role and how to differentiate them from other health care providers on the team. The lack of experience the team and organization may have with the role may potentially become a strong obstacle in the integration of the peer support providers (Moran et al., 2013).
- Role conflict: Peer support providers may experience role conflict in two ways when performing their services on the team, with implications for both clients and staff. The first type of conflict occurs between the roles as a peer support provider and as a member of a health care team in a mental health organization (Moll et al., 2009). The peer support provider occupies these two roles simultaneously, creating a challenge for the clients to differentiate between the two roles. The contradictions between these two roles may lead clients to “perceive [peer support providers] as staff and lose trust in them” (Carlson et al., 2001, p. 206). The second type of role conflict occurs as peer support providers attempt to balance their role as service provider with their role as service user (Carlson et al., 2001, p. 206). This dual role may be ambiguous for staff members, who may view peer support workers as "clients and not as equal colleagues" (Carlson et al., 2001, p.206).
- Disclosure of illness experiences to team members and clients: A study by Moran et al. (2013) found that staff members sometimes lacked sufficient understanding of the value of lived experiences for service recipients. One incident in the study involved a supervisor restricting the amount of disclosure done by the peer support provider. This lack of understanding may be brought on by insufficient education of the team and staff prior to the role integration on the team.
- Blurred boundaries when relating to clients: Peer support involves sharing personal experience with mental illness and the recovery process. It is therefore much more difficult for peer support providers to set up and maintain boundaries with clients

(Mowbray et al., 1998; Carlson et al., 2001, p. 202-206; Gate & Akabas, 2007). It places the peer support provider in a difficult position of balancing their role as a provider and friend in the relationship.

- Low pay and hours of employment: Low hours are associated with less opportunity to integrate within the team and interact with team members (Walker & Bryant, 2013). Additionally, peer support providers may feel stressed by their lack of job security (Walker & Bryant, 2013; Repper & Carter, 2011).
- Isolation on team: Peer support providers who are sole providers in their organization or team may find it difficult to develop networks with other peer support providers in other health care organizations (Moran et al., 2013). Additionally, as a sole provider, a tokenistic identity may make it difficult for the peer support provider to promote systems change in an organization (Lammers & Happell, 2003).

At the moment, limited information is available regarding the different types of barriers experienced by the diverse peer support models of employment within inter-professional mental health teams. Additionally, only a limited number of studies have focused on the enabler aspect of peer support provider integration within mental health teams. Literature concerning the integration of peer support providers within teams has been limited to a few studies (Richard, Jongbloed, & MacFarlane, 2009; Gates & Akabas, 2007; Walker & Bryant, 2013). These studies have often looked at the addition of a peer support provider alongside traditional mental health services and have not explored knowledge about different types of barriers in their integration as equal members of the team.

2.3. Standardization of Peer Support Practice

Several studies looking at barriers to peer support provision have included role ambiguity as a primary barrier (Solomon & Draine, 1996; Gates & Akabas, 2007). Studies have identified that poor job descriptions and role ambiguity make it difficult for peer support providers to integrate into multi-disciplinary teams (Gates & Akabas, 2007; Jacobson et al., 2012). Vague role descriptions have prevented staff and team members from understanding the best method to relate to peer support providers (Dixon, Krauss & Lehman, 1994; Jacobson et al., 2012).

In order to remove this barrier to support provision, many institutions and organizations provide training to peer support providers. In the United States for example, studies have been conducted to look at the benefits of working as a trained and/or certified peer specialist. One recent study, performed by Salzer, Darr, Calhoun, Boyuer, Loss, Goessel, Schwenk, and Brusilovskiy (2013), examined certified peer specialists “as an emerging workforce across the United States... as essential components of the recovery-oriented mental health systems” (p. 219). In some states, such as Kansas (Ratzlaff, McDiarmid, Marty & Rapp, 2006), New York, and Georgia (Campbell & Leaver, 2003), peer support providers obtain certification training from approved organizations (Chinman, Salzer & O’Brien-Mazza, 2012). The training involves learning about “recovery tools, facilitating mutual support groups, effective listening and asking questions, problem-solving with individuals, planning and accomplishing recovery goals, dealing with ethical and workplace issues, and mental illness basics” (Chinman et al., 2012, p. 472). In the case of Veterans Affairs, peer support providers require certification in order to be reimbursed for their services through Medicaid (Chinman et al., 2012). The process of certification creates the culture of continued education and fosters different techniques for the improvement of peer support provision (Chinman et al., 2012).

A report entitled *Making the case for peer support* discussed concerns related to the introduction of certification for peer support providers (O’Hagan et al., 2010). While some peer support providers in Canada express reservations that the professionalization of their role might undermine peer support values (O’Hagan et al., 2010, p. 70; MHCC, 2013, p.19), others feel the need for peer support to “become more standardized with nationally recognized training and standards that can be adapted at the provincial level” (O’Hagan et al., 2010, p. 70). These contradictory perspectives suggest the need for more research into the potential implications of a national certification program for peer support providers.

Peer Support Accreditation and Certification Canada (PSACC), as discussed earlier, is an organization grounded in evidence-based practice that provides an accreditation opportunity to peer support providers who work in formal models of peer support. This voluntary certification process is supported by the Mental Health Commission of Canada

(MHCC) to give peer support providers knowledge about developing relations with clients (MHCC, 2013). In order to counter any concerns that the professionalization of peer support may undermine peer support values, the PSACC has made the three primary values of peer support the underlying foundation for the certification. The three values include self-determination and equality, mutuality and empathy, and recovery and hope (O'Hagan et al., 2010; MHCC, 2013, p. 19). Additionally, the PSACC has indicated that this certification will only be provided on a voluntary basis. An advantage of this certification process is the recognition of the peer support role by other health care professionals and mental health staff (CMHA Conference, Oct. 17, 2013). There have not been any studies conducted as of yet looking at the new national certification program in Canada or at the perceived potential implications of introducing this certification for peer support providers.

2.4. Gaps in Literature

Peer support is becoming an important component of recovery-oriented mental health services in Canada. There have been several studies in Canada and internationally looking at the benefits, barriers and integration within mental health programs. However, there are still gaps in the literature regarding how peer support providers' roles are constructed within inter-professional mental health teams. Given that there are different models of peer support employment (Appendix 8.1), and that there is no standard definition of the peer support role, peer support providers may be assigned a variety of responsibilities within inter-professional teams. There is a need to understand how peer support roles are constructed in different employment models. This knowledge, however, is not available in the current literature.

Additionally, different models of peer support employment may entail different obstacles and enablers. At the moment, studies have examined the general barriers and enablers often faced by peer support providers in delivering their services within teams (Miyamoto & Sono, 2012, Repper & Carter, 2011) but have not focused attention on the different types of enablers/obstacles that may occur in various peer support models.

Finally, the recent introduction of the PSACC certification process has opened a gap in the literature. Currently, there are conflicting views regarding the certification process.

Some peer support advocates state that the certification process will make the role of a peer support provider too bureaucratic and professional, undermining the peer support values (O'Hagan et al., 2010, p. 70; MHCC, 2013, p. 19). Research on the 'certified' peer support providers has been conducted in the United States at a state-level (Salzer et al., 2013; Ratzlaff et al., 2006; Campbell & Leaver, 2003) but there is a need to understand how certification – at a national level – is perceived by peer support providers working in the Canadian context. These gaps will be addressed in this study.

3. Methodology

The purpose of this study is to explore peer support providers' views of a) how their roles are constructed and defined within an inter-professional mental health team; b) the factors that influence their integration and subsequent work within teams, c) the contributions and implications of such integration to the clients, the teams, as well as the peer support providers themselves, and d) the implications of introducing peer support certification. To explore these themes, a qualitative study was conducted using interviews.

This section will provide the reasoning behind the qualitative methodological approach used in the study. Following this, the data sources, study setting, and sampling techniques will be presented. The last section of the methods will provide information regarding data analysis and presentation.

3.1. Methodological Approach

Qualitative approaches allow researchers to gain a complex and detailed understanding of the subject of study (Creswell, 2013). Understanding the context and setting of the participants' experiences was integral in identifying the factors influencing role construction. Creswell (2013) states that qualitative studies provide the opportunity for researchers to present the participants' perspective and gain a better understanding of their relationship with the surrounding elements. In using this approach, I was able to study the dynamics behind the development of the peer support role as well as its implications to different stakeholders.

Miles, Huberman, and Saldaña (2014) state that qualitative methodology allows the retrieval of data directly “from the inside” of the field and serves as an opportunity to obtain data that is descriptive and reflective of the participants’ “lived experiences” (Miles et al., 2014, p. 11). Qualitative study is uniquely positioned to explore participants lived experiences in context (Marshall & Rossman, 2011, p. 92). In using this approach, I was able to gather descriptive data directly from participants about their experiences in taking on the role of a peer support provider on a team. Participants had the opportunity to explain and elaborate on their personal experiences and views. Moreover, participants were able to share real-life examples from their role integration, expanding on factors enabling or preventing their service delivery on the team.

By using a qualitative approach, I was able to “achieve depth of information (rather than breadth) by ‘mining’ each participant deeply for their experiences on the research topic” (Hennink, Hutter, & Bailey, 2011, p. 17). Thus, a qualitative approach provided rich, contextualized information that would have been difficult to obtain with surveys. Interviews were useful for this particular study because they allowed me to gain insight into the more complex factors influencing the participants’ integration within inter-professional mental health teams. For example, if participants mentioned a new concept that was not originally part of my interview protocol (e.g. role duality), I was able to delve into the topic for further examination.

3.2. Data Collection

3.2.1. Data sources.

Data sources for this study included: 1) interviews with peer support providers as a major source, and 2) documents and reports as supplemental sources of information on the context of the peer support model.

Interviews for this study were semi-structured and open-ended. The utilization of the semi-structured format rather than a structured format allowed me to adequately explore the issues and probe the participants for further information as they shared their experiences (Patton, 2002, p. 343). This aspect was useful when discussing the types of factors

influencing the participants' role construction and integration. For example, one ACTT peer support participant mentioned their experience of role duality as an enabler to integration on the team. This concept was used as a probe in later interviews with peer support providers' sharing similar dualities. The interview protocol is available in Appendix 8.2.

I conducted 12 interviews ranging from approximately one to two hours each. The interviews were digitally recorded and transcribed verbatim. Following every interview, I prepared a contact summary form using the outline in Appendix 8.3. Creating a contact summary form was useful in summarizing the overall interview information and for making pointers and recommendations on what areas to focus on in the next interview (Miles et al., 2014, p. 126).

Documents were requested from participants and program managers to provide information pertaining to the peer support provider practices and role in the team (e.g. training modules for peer support providers, program service description). These documents were obtained from participants or retrieved from websites. I used this data as a source of information regarding the context of peer support providers' work and role definition. For example, I was provided with training manuals (e.g. WRAP, Pathways to Recovery).

3.2.2. Sampling.

The participants interviewed for this study included peer support providers from two types of formal peer support models: Assertive Community Treatment Teams (ACTT) and non-ACTT. Participants were recruited from these two different general models, where peer support providers offer services, but with varying degrees of integration with other health care professionals. ACTT was identified as one model, recognizable as a type of individualized community treatment team available provincially across Ontario. Whereas, non-ACTT models included any type of program where peer support providers were employed in formal settings (e.g. in-patient programs at hospitals).

Participants were selected using purposive and snowball sampling (Miles et al, 2014). Purposive sampling allowed for the selection of participants working in different peer

support environments. Snowball sampling was used in participant recruitment due to close social networks among peer support providers. Snowball sampling is often used “for locating information-rich key informants or critical cases” (Patton, 2002, p. 237). This was a particularly useful approach in finding peer support providers in a limited pool of participants. Initial contacts to recruit participants were made with program managers in mental health programs. These individuals were asked to suggest peer support providers in their programs who were potentially willing to participate in the study. However, most of the participant recruitment occurred through snowball sampling where participants sent out my recruitment poster to a provincial peer support network. In order to ensure that no coercion took place and that participants did not feel pressured to participate, I made sure that the program managers and other peer support providers did not know which participants chose to take part in the study.

3.3. Data Analysis

3.3.1. Grounded theory approach.

This study used a mixture of deductive and inductive analysis, and followed some of the procedures of the grounded theory approach as described by Hennink et al. (2011) and Charmaz (2006). Grounded theory, as an approach to data analysis, is a circular process of analytic activity where many stages of the coding and analysis process overlap, allowing for the exploration of emerging themes (Hennink et al., 2011, p. 208). Grounded theory initiates the analysis process alongside data collection, enabling memo writing and coding to allow the researcher to probe for emerging themes in later interviews (Charmaz, 2006). This approach offers the opportunity to develop or extend theory based on analysis of the data (Hennink et al., 2011; Charmaz, 2006).

3.3.2. Coding and analysis process.

Hennink et al. (2011) describe the grounded theory analytic process as a cycle involving multiple steps, including development of codes, description and comparison of data, categorization and conceptualization of themes, and development of theory. Grounded theory is largely an inductive approach, but it also encompasses deductive analysis. Hennink

et al. indicate that some codes may be based on the research instrument such as the interview protocol “as derived from the conceptual framework of the study (deductive), while other codes are developed by directly reading the data themselves (inductive)” (2011, p. 210).

The deductive codes are developed by the researcher based on the review of literature, and subsequently followed by the revision and addition of inductive codes based on the reading of interview data (Hennink et al., 2011, p. 218). In my study the interview protocol was developed based on my literature review, and it served as a foundation for my focus on particular topics in the interviews. Some examples of my deductive codes included: job description, training, and stigma as an obstacle; these codes held significant importance in the literature. However, the manifestation of these elements in different types of peer support models was not reported in the literature. I analyzed how these themes were manifested for peer support providers in different contexts. The inductive process involved attending to themes in the interviews that may not have been addressed in the literature.

Analyzing the interview data involved an initial coding where one familiarizes oneself with the transcript (Charmaz, 2006). Rather than only coding line by line, as suggested by Charmaz (2006), I coded paragraphs to provide context for what the participants were discussing. This strategy was comparable to Strauss and Corbin’s suggestion about paragraph coding, which allowed for a detailed analysis of the concept (1998, p. 120). Hennink et al. (2011) recommend that the initial reading of data “identifies the more explicit codes, where the issue is clearly evident in the data” (p. 221). Memos accompanied this process to keep track of any new ideas or themes emerging from the data, which may later become codes (Charmaz, 2006, p. 115; Hennink et al., 2011, p. 221). In grounded theory, memo-writing is a “crucial method... it prompts you to analyze your data and codes early in the research process” (Charmaz, 2006, p. 72). Memos served as quick and short outlines of ideas. During this process, I kept notes regarding any patterns I saw in the data. For example, when I was coding the data, I saw a reoccurring theme on the lack of training as a prominent obstacle for peer support providers in their role construction and integration.

I also developed a codebook that included a list of codes with definitions to be used as the central reference for the coding process (Hennink et al., 2011, p. 225). I used the codebook to explore potential ways to categorize the codes and concepts. For example, I created a general code for 'role construction' which included smaller codes such as 'disclosure of illness' and 'interactions with team members'. I used a data analysis software (Atlas-ti) to facilitate my data analysis process. This software facilitates the manipulation of large volumes of data, allowing one to conduct complex searches of codes and topics quickly, and easily document the trail of searches and results (e.g. save dates, label searches, keep memos) (Hennink et al., 2011, p. 237).

Going back and forth between interviews and comparing codes assisted in identifying patterns, such as similarities and differences between the two models of peer support. I used tabular arrangements (Miles et al., 2014) to summarize and compare the findings.

3.3.3. Trustworthiness of findings.

The trustworthiness of my findings was established through different steps. My study went through an ethics approval process by the University of Ottawa to insure that there were measures in place to protect the participants' anonymity and confidentiality (e.g. consent forms – Appendix 4). Additionally, I developed an interview protocol to prevent bias in the type and format of questions asked. Patton (2002) recommended that researchers construct neutral questions and maintain a neutral stance when collecting participant responses and feedback during the interview (p. 365). As importantly, my supervisor reviewed extensive portions of coded data to provide a reliability check on the analysis I conducted. This debriefing step involved a person acting as "the devil's advocate" to ensure that hard questions were asked of the researcher concerning methods and interpretations (Creswell, 2013). Furthermore, my study established trustworthiness through extensive use of quotations from participants' interviews to provide context of their experiences. In doing so, readers will be able to interpret directly from participants' perspectives (Creswell, 2013; Lincoln and Guba, 1985).

4. Findings

4.1. Introduction to Peer Support

In order to better understand the role of peer support providers in the mental health field, it is important to be aware of the background of the person prior to his/her taking on the role. The majority of the participants recruited for the study felt it was necessary to discuss how they came into peer support before going into details about their current peer support provider role. All participants mentioned their lived experience and recovery as part of their journey to providing peer support in their current role. Table 4 provides information on participants' career backgrounds to facilitate the understanding of their introduction to the peer support role. Participants have been identified respectively as 'APS' or 'PS' for their integration on an Assertive Community Treatment Team (ACTT) model or a non-ACTT model.

4.1.1. Illness experience.

There was no visible difference between APS and PS in their illness experience. However, only three PSs participated in support group therapies while only one APS took part. Most participants had lived illness experience involving hospitalization. Several participants commented that they did not have peer support services available to them at the time of their illness. This might have been due to the lack of awareness or access to peer support services. When asked if at the time of their illness, they had any peer services available to them, we obtained a common answer:

“Not even close. I think [peer-run initiatives] started up in the early 90's because people were unhappy with the system at that point. There weren't a lot of alternatives to seeing a psychiatrist and say 'here's your medication'. So, a lot of these consumer survivor initiatives started because people wanted other things for themselves from the community.” APS2

A few participants had the opportunity to engage in more recovery-oriented therapies (e.g. Cognitive Behavioural Therapy (CBT), Dialectical Behaviour Therapy (DBT), day programs). Only 4 participants had actively taken part in support groups during their

treatment and/or post-treatment. The participants in question had found support occurring naturally in their therapy groups:

“I had never experienced any peer support provider in my care. I guess the closest that I came would have been – and I’ll always say that this was probably the biggest turning point in my recovery – was going to the DBT treatment, because there were half a dozen other people in that group who were experiencing the same thing. It was without a doubt the first time that I realized that I wasn’t alone in my struggle.” PS4

Only one participant had engaged in peer support groups as part of their recovery. The participant found peer support as a significant, if not the most important, component of their recovery.

“I had a really tough time trying to sort things out and manage my life, and I was stuck in my illness until I discovered peer support... [Peer support] was such an important factor for my own recovery, and discovery of reaching my full potential that it became an important part for me... I took the peer support training, became a volunteer peer supporter... and then eventually became a paid peer supporter.” PS1

Some participants mentioned that they had found informal support among health care professionals treating them. Participants commented that they found a more humanistic perception of the health care system when a health care professional engaged with them on a more personal or informal level. The participants mentioned that the health care professionals provided hope for the PSP that they could improve:

“The early years nurse was an absolute lifesaver...She was a huge source of support to me and to my family... She was the first person I think in my whole mental health history said to me, “You’re sick.” Not, “How do you feel?” But, “You know what [Participant AP5]? I know you, I know what you look like when you’re well, and this ain’t it.”... To me, she was that peer. Also a nurse, also a mom. But very able to

recognize that I wasn't able to ask for help...and that I really needed somebody to intervene in my own life, to help me get better." APS5

"I started not feeling well at all and it got really bad. I couldn't take anymore... I stayed there three months. It was a long time and the psychologist there told me that he saw sparks in my eyes. That really touched me and helped me get out of that, just those words. I see sparks in her eyes made me feel special, made me feel like I could get out of that hole and in health. So that helps a lot." APS7

This engagement with health care professionals and participation in recovery-oriented therapy helped many peer support providers take a pivotal turn in how they viewed and managed their health. Additionally, this interaction between the health care professionals and the peer support provider may have facilitated changes in participants' trust of the mental health system:

"I remember there was a doctor I worked with...who actually talked to me about wanting to work, not just towards a sense of symptoms and side effects but that we were working towards a quality of life... That was kind of pivotal for me to realize that there were people in the mental health system that were doing things that could be good or helpful, or hopeful." PS2

There were a few peer support providers who mentioned negative encounters with health care professionals during the course of their treatments. These participants expressed that there were incidences in which they were stigmatized for their diagnosis by their health care professionals. This interaction often included health care professionals mentioning inability to recover from illness.

"What I really questioned was [what] the doctor at that point told me...he said when you are ill, you are going to be ill the rest of your life. You are going to be on medication the rest of your life. You will probably never ever work again. You might as well accept this and get on with your life. And I remember thinking at that point,

what life? You've just told me I don't have one. And [I] just could not accept that diagnosis.” APS8

Most of the participants were introduced to the topic of peer support by: 1) seeing job postings on-line, in the newspaper, or internally within the organization; 2) working/volunteering at peer support groups; 3) university/college educators; 4) PSP's psychiatrist or health care professional; and 5) using it as a component of their treatment.

4.1.2. Decision to work in peer support.

Several participants mentioned negative experiences with the system during their illness. There was a trend among the participants to utilize their negative lived experience as a positive tool to help others. All participants mentioned that they wanted to provide a voice for clients on the team and use their own experiences to provide insight to team members:

“... Mental illness doesn't have to be a weakness... It can be a positive thing, right? Because here are you are working, even though you have this mental health challenge, you can use it as a strength, not a deficiency.” PS1

Additionally, several participants commented that working as a peer support provider gave them the freedom to disclose their status as person with lived experience. Participants mentioned that in many of their past employment, there was stigma concerning disclosure of lived experience. This was often associated with having significant gaps within their employment history. Working as peer support provider would enable the discussion of aspects of their illness that would not be discussed elsewhere.

“...I didn't actually find any work that would bridge the gap. I was just doing a little bit of contracts here and there and I wasn't finding much in the way of work... When the job application came across my path for this job, I actually looked at it and I had everything they were looking for. It's actually the first time in a long time, if not ever, that I found a job posting that... I have everything they were looking for.” PS2

Other motivations mentioned by participants to work as a peer support provider included personal interest, gaining employment, financial remuneration, gaining experience in mental health field, and changing the culture of mental health system.

4.1.3. Career history.

Participants recruited as part of this study had a wide range of career histories prior to taking on the peer support provider role. Several participants moved from one employment to another due to their unwell periods and hospitalization, preventing them from working long periods of time. Participants stated that they worked during periods of wellness and health stabilization but were unable to retain their positions when they experienced longer periods of illness.

APS and PS participants had varying educational and career backgrounds. Approximately one third of the participants have a professional designation or experience working in a clinical role. Most of the participants had no background experience working in a mental health care environment.

Table 4 provides a summary of the career history of each study participant. Due to the close knit community of peer support providers, the occupational categories have been generalized to prevent identification. Definitions of the various categories are available in the table.

Table 4. Summary of Peer Support Provider Career History												
	ACTT								Non-ACTT			
Type of Occupation	APS 1	APS 2	APS 3	APS 4	APS 5	APS 6	APS 7	APS 8	PS1	PS2	PS3	PS4
Psychosocial ¹	+		+				+				+	+
Medical ²					+	+		+				
Community Outreach ³		+	+	+				+	+	+	+	+
Government Employees ⁴						+	+					
Educator					+		+					
Research/Scientist	+			+								
Miscellaneous ⁵	+		+			+	+	+	+	+		+
1 – Psychosocial: Social Work, Community Support Provider 2 – Medical: Nurses, Personal Support Workers 3 – Community Outreach: Individuals working in community health centres and peer-run initiatives. 4 – Government Employees: Administration; Military personnel. 5 – Miscellaneous: Artist, Construction, Secretary/Administrative, Security, Stay at home parent, Spiritual clerk, Server												

4.2. Experience with Current Peer Support Provider Role

There were variations in the participants' experiences of integration within the team. These variations can be attributed to obstacles and enablers influencing how participants' integrate as peer support providers on teams. Obstacles and enablers as influencers can be seen in multiple forms and levels throughout the participants' journeys to role integration. These elements will be discussed in the following sections concerning the participants' experiences of role development and the implications of these influencers on their role.

4.2.1. Role integration on team.

For most professions, integration of a role into a health care team involves multiple steps. However, as the peer support provider is fairly recent in Canadian context, there are further steps involved in their integration. Job description, role title, training, and responsibilities are all important elements of a newly developed role. These elements will be discussed to provide insight on the similarities and differences observed across varying models of ACTT and non-ACTT.

4.2.1.1. Posted job description.

The job description was brought up by most participants in the interview. Most participants were initially introduced to their proposed role on the team through job posting. Overall, there was agreement among participants regarding the vagueness of the job description that was posted.

“Nowhere in the ad did I find that it was with an ACT team and I didn't know what an ACT team was. It was a double-blind kind of application but I liked how it was worded. I liked what they were looking for and I honestly thought it was peer to peer for colleagues in the hospital... I came for my first interview with the program manager and the department director who asked me about my knowledge of ACT standards. And I smiled and said 'Pardon?'” APS5

“It’s been very interesting because... the ad, the posting basically said medical experience required... As a dentist? As a medical secretary? As a nurse?” APS5

Most participants described the posting as indicating very few requirements in addition to lived experience.

“It [job posting] didn't say much, it said that you had to have experience with mental health and as a client, not necessarily as a provider. But that you were able to function okay, like take a full-time position... And pretty much be an advocate for the clients. It was very vague, very general, and that pretty much everyone who could, could have gotten the job.” APS6

“I saw this role and was reading it and it sounded like a typical social work role, and then it got to the bottom and it said as a requirement, must have lived experience.” PS4

Only two APSs reported requiring a college or university degree. A few of the positions required the applicant to have had experience working in the mental health environment.

4.2.1.2. Role title.

Position titles on teams provide an understanding of how the worker is viewed on the team. There was a clear difference between the APS and PS position title. APSs had very little variation in their title namely, were ‘Peer Specialists’ or ‘Peer Support Workers’. Some of the participants mentioned an additional title, such as ‘Mental Health Counselor’. In most situations, the participants explained that they were grouped under the same umbrella title as Addictions Specialist and Vocational Specialist. This also meant that the peer support provider was usually paid under the same pay scale.

“The actual official title is a Mental Health Counselor - Peer Specialist. Because we have several mental health counselors on the team and one is an addiction specialist

and we used to have a vocational specialist. I would be equal, completely equal. I get the same level but I am a peer specialist. But I will usually use that peer specialist designation so that people know... that I am doing something different and that I have different experience.” APS1

“My title is Mental Health Worker but my speciality is Peer Specialist... One of the [mental] health care workers [on the team] is a vocational worker and the other mental health worker’s specialty is addictions... Our pay scale is under that, as a mental health worker, but as a specialty, it’s peer specialist. I just say peer specialist whenever someone introduces me because... it kind of identifies.” APS2

The relative uniformity in title is primarily due to the ‘Ontario Program Standards for ACT Teams’ that designates the position as “peer specialist”.

“They have what they call ACT Standards, each team is supposed to follow the ACT Standards. There is supposed to be a Psychiatrist for this amount of days of the week, there is supposed to be a certain amount of Nurses, and there is supposed to be a Peer Specialist on the team... It’s not like it has to be enforced, but generally, most teams across the province do have a Peer Specialist.” APS2

Participants on non-ACTT models had more varied role titles. These titles included ‘Peer Support Worker’, ‘Care Recovery Facilitator’, ‘Community Support Counselor’, and others. Some of these titles did not reflect the peer support role of the participants. One participant mentioned that in order to change the role title, the job would have had to be reposted as another employment opportunity open for all union members.

“... If I wanted to see a change in my title, my job would have to be reposted...Because it's a union. I'm part of a union, and you can't just change things without certain things being accomplished through the union.” PS1

ACTT peer support providers' uniform title of 'Peer Specialist' implies that this position has generally similar responsibilities across all teams. In non-ACTT models, the variation in title may reflect differences in the participants' responsibilities and interaction with team members and clients.

4.2.1.3. Training.

The training received by the participants varied across ACTT and non-ACTT. Among ACTT, all participants received introductory training provided to all staff members in the organization. In addition, most APS participants mentioned that they shadowed a team member to learn about the ACTT general duties.

"We do progress notes... The team showed me all that. The team showed me everything about doing everything in the office... I was with other people for two weeks... at the beginning, and then I was on my own." APS7

Most of the participants had received some training related to peer support and recovery in their organization; this training, however, varied in terms of depth for each of the participants. Only three APSs had gone to multiple workshops and training programs concerning peer support. One of these participants had been given paid time to train and access resources at a local peer-run initiative.

"...I started signing up and for the next year I was going to [a peer-run organization] regularly for their courses. My employer supported me the whole time and they paid for the parking and gave me the time off. Like paid time. So they were really good for that. And that gave me the training or what I needed to feel comfortable with my job." APS6

Two of the APS participants were given the opportunity to shadow a peer specialist on another ACTT. There were only a few participants who had received minimal training for peer support or recovery due to limited peer support learning sources.

“There wasn't really anything in the way of training. There was some research becoming available, so I did a lot of reading. There weren't really a lot of people to talk to, because this was just brand new.” APS8

In these cases, the participants chose to pursue peer support training by accessing educational forums, taking online courses, and visiting local peer-run initiatives. The findings were similar for non-ACTT participants, though most had obtained training from their current workplace. There was standard training provided to all staff members of the organization.

Overall, both APSs and PSs shared similar types of peer support training with the most common training being the Wellness Recovery Action Plan (WRAP) and Pathways to Recovery. The most significant difference between the ACTT and non-ACTT participants was that some APSs found it necessary at times to have some training or education about clinical terminology in order to communicate with their team members. When asked about clinical terminology and the team, one APS with a clinical background responded:

“Yeah, without that [clinical terminology/experience] I would have been terrified. I have been very thankful that I had a nursing background to come to this with...” APS5

Other APSs indicated that they had taken courses or had learned the terminology from their team members.

“...I knew I was doing the right thing but I didn't know how to argue in the meetings. There were all these very well educated people and... they would start with their rehabilitation lingo... Almost immediately, there was a course... 2 years part-time, I took that and it was like exactly what I wanted to know.” APS1

“...I have a chart from [Peer-run organization]... it's a sheet that gives me something that is being said, and how you say it when you talk to peers, and how you say it

when you're in the mental institution... when I'm with my coworkers, I try to use the language of coworkers. And when I'm with peers, I use the language of peers. That's what I'm working on right now.” APS7

“I had a super supportive manager... She invested a fair amount of time with me in the beginning... once I got the groundwork done and the foundation established, I was on my own and they trusted me completely. I just ran with it. We always need each other, they taught me the basics, I learned them and after that I was on my own and off running...”APS4

Clinical training was not mentioned as a necessity by non-ACTT participants. Peer support providers who have less contact with other clinical team members may require less knowledge of clinical terms.

4.2.1.4. Responsibilities.

APSS’ role responsibilities were notably different from PSSs’ responsibilities. The ACTT Program Standards provide general guidelines for what is expected of all members during their work hours. ACTT members function with mainly generalist roles for a large proportion of their day. This generalist role means that peer support providers perform the same types of activities as other members, while maintaining their peer support and recovery perspective for the team and client. All team members share the generalist role, which includes client assessment, team meetings, and daily medication delivery/appointment accompaniment for all clients on the team. This is not applicable in the case of non-ACTT participants as there are no Program Standards; therefore, there is a larger variance in how the role is enacted.

All APSs described ACTT in a very similar manner, by indicating that their program was holistic with the main goal of keeping clients out of hospitals.

“It's making sure people get medications. Get connected to services... All aspects of health is cared by the ACT team because it's... holistic, it looks after every aspect of

their lives. Housing, emotional well-being, physical well-being, the whole thing.” APS3

“We do anything and everything to keep people in their homes. Well, we’ll go grocery shopping, side by side cleaning of the house, side by side cooking, anything to help them. It’s individualized services.” APS1

This level of contact with the clients was described by many APSs as being recovery-focused, where team members focused on enabling clients to be as independent as possible. One participant compared ACTT with a hospital, commenting on how ACTT is working alongside the clients rather than interacting with them using in a top-down approach seen at hospitals. It should be noted that APSs interacted with clients in the community and in their homes. There was agreement among APSs regarding the generalist role, as all APSs commented on how all members of ACTT had a generalist role with underlying specialties, used when necessary.

“I have a case load, in that sense, I am responsible for everything. Case load meaning, we’re a shared care model... We share working with everyone, we bring our distinct professions and specialties to the field, right? If a person needs help with housing, I support them with housing... Similarly with finances, if they need support with their finances, I’ll support them with their finances... Everything and anything that needs to be done, I’ll do and that’s a part of my role.” APS4

APSs stated that they spend most of their time in generalist role activities.

“There’s only one thing I do with our clients right now that is specific to my role, because on the ACT team, I think we all spend about 6 hours a day doing general stuff and the last 2 are for your specialty. I do supper club...” APS5

Nearly all of the APSs commented on how their job description was vague. This vagueness often times assisted the APS participants in deciding how their role would be practically implemented; some saw this as an opportunity for flexibility of their role.

“... When I started in this role, the job description was so vague that it was basically whatever I wanted. I've been working on it for the last few years to define it... We all basically do 90% of the exact same work. Where it differs is with a lot of clients I have a better relationship, because I can relate to them on like, I take meds like them. We can relate a lot more on that aspect... Of dealing with being sick and the stuff we have to do to get through the day.” APS6

Other APSs had difficulty in visualizing and enacting their role. One participant commented on how she had not known her role was largely generalist until she sought advice from fellow team members.

“Well, the first person to tell me that my job was a generalist role for the majority of the day was a psychiatrist and that was on week six. I finally walk up to a doctor who I felt very comfortable with, and I'm like, 'Do you know what my job description is? You've been here the longest'. And he said, 'Everyone on the team has a generalist role for the majority of the day'. And I'm like, ok I get that. I've done that part now, but now what am I supposed to do? I think that identifying what the team needs a peer support worker to do... is really helpful.” APS5

In other cases, APS participants mentioned that they had a useful job description in place allowing them to more easily take on the generalist and peer support role. Some APS participants mentioned that the team's interest in the role of the peer support provider facilitated enactment of the role.

“They had a pretty good job description of what it was. And they had a peer support worker there before but it was really new so...I think most of it was the fact that they

were invested in it and they wanted a peer support worker. That's the main thing and the rest of the team as well knew about the role." APS2

APSs reported that their role also included engaging with clients in a manner that other team members could not, as well as advocating for the client's perspective on the team and organizing therapeutic social activities and events for clients. A few APSs mentioned that developing a relationship with the client was a key responsibility as recovery was visualized differently by each person.

"Specifically, in regards to peer support, I think building a relationship and making a connection in having that unique sort of bond that you can form is probably the key goal, in my opinion. Although that's very vague, because you do that totally individually and uniquely and differently and specifically to the individual." APS8

Most of the APSs mentioned holding social therapeutic activities as part of their interaction with clients. These activities included one-on-one interactions and group activities with other clients. In most cases, the activities were initiated by the APS with interest from clients; most APSs commented on how these alternative therapies were accepted and encouraged by their team members. An APS stated:

"I started up a yoga group a couple years ago for clients... We provide free yoga class to clients because they can't afford it... I think the idea of peer support is that they bring a different flavour to the team. A lot of people who've experienced mental illness will use different therapies for themselves... You'll see a lot of peer specialists who will bring something different like an alternative therapy..."

As mentioned earlier, PSs' responsibilities tended to be somewhat different from the APSs' responsibilities; however, the main peer support responsibilities remained applicable to most of the PSs. The differences may be influenced by the fact that all of the participants in the non-ACTT worked part-time. Additionally, PSs provide their services in a variety of

environments. The PSs tended to work within hospital in-patient programs, local health centres, community outpatient intervention programs, and case management teams.

Most of the PSs spoke about at a vague job description, but found this to be an opportunity to explore their role with more depth. They mentioned that they had flexibility in exercising their role.

“The way I see my role, I think it's growing and expanding and has been developing over the past two years here. When I was hired on, it was sort of more or less the description of the job. As soon as I was hired, they were like, 'All right and now you're going to define what this job looks like'. Basically, I was given pretty much free range to define this position when I got here.” PS2

“When we started out it was pretty clear when they were explaining the role to us that we would have a lot of discretion and leeway around how we would carry out our duties, our work”. PS3

PSs' responsibilities involved developing a peer relationship with the clients and setting boundaries welcomed by both sides. The relationship between most PSs and clients seemed more informal when compared to APSs. Most PSs shared similar role responsibilities, including advocacy work on the team, one-on-one meetings with clients, and facilitating group activities.

“...my role here is to provide... support through listening and reflecting back to people that I work with. I work with people one on one through their experiences, supporting them, providing an opportunity to discuss it. And where appropriate, to identify with it. And just to help them know that there are people who have been through things and have actually come out the other side in good place. I feel like a central part of my role is about holding hope for people and offering it to them.” PS2

Some PSs also had administrative responsibilities such as managing files.

Overall, there seemed to be some role ambiguity for both APSs and PSs. APSs had to work in a generalist position for a large proportion of their work hours, while dedicating a smaller percentage to peer activities. This left some APS participants uncertain about how to manage their peer support services in the remaining time. In non-ACTT programs, most PS participants faced a vaguely described role but had greater flexibility to define their role. PSs only had to focus on their peer support provider role whereas APSs had to take into account their generalist role.

4.2.2. Relationships with team members.

APSs and PSs listed similar professions when asked about the members on their teams. Typically the professionals included Psychiatrist, multiple nursing positions (e.g. Registered Practical Nurse and Registered Nurse), Social Worker, Occupational Therapist, Team Manager (e.g. Nurse, Psychiatrist, etc.), and Addictions Specialist. Other positions that were often mentioned included Recreational Therapist, Vocational Therapist, and Mental Health Worker.

PSs only mentioned a few roles that were not addressed by the APS participants, including Personal Care Assistants and Family Educators. These minor differences in positions may be attributed to the types of service provided or the clientele of the non-ACTT programs.

4.2.2.1. Frequency of interaction with team members.

There were notable differences between APS and PS participants when they discussed their interactions with team members. APS participants interacted with team members in order to relay information during daily meetings. The participants worked alongside team members to provide ACTT services to all clients. Most participants mentioned having shared case loads and interacting with other team members to discuss clients' concerns. They also spoke about being approached for information on peer-specific issues.

“I’ve become the source of information for all these things about patient's rights... everything that has to do with [peer support], they come and see me, because they know that's my bailiwick.” APS6

“... It’s a lot of ACT stuff that I do but every once in a while will be certain things that are my specialty... people were like, 'Oh, we understand what you do and we see how you work', and they would bring me a client, or... they would say, ‘So and so wants more information about [peer-run organizations], could you take them there? Or you could just talk to them about [peer-run organizations]’...” APS3

In non-ACTT, there were variations in the frequency of interactions between PSs and team members. In some cases, participants would interact each time they were at work, while others would mainly interact when they received a referral about a client. Further, PS participants were found to interact more closely with particular groups of health care professionals.

“The people I interact with most, I would say would be the other Allied Health. Particularly, the Occupational Therapist and the Rec Therapist. Those are the people I work more closely with. At least in part, if not a large part, [due] to their own desire and willingness to work with me...” PS2

“My colleague is the vocational specialist... She helps coordinate the program, she leaves a lot of it for me to do, because that's my role, but she oversees it... I have the most interactions with her... She knows what I do very well, she has lived experience too.” PS1

The fact that PS participants interacted more with particular types of health care professionals may show that certain professions are more open to the peer support provider role. Some of the PSs discussed their collaboration with team members in order to host peer-related activities. This type of selective interaction and collaboration for peer-related activities was not as visible among APS participants.

4.2.2.2. Role acceptance.

APS participants stated that they were recognized as peer support experts. Most participants felt that their role on the team was well understood as a peer support provider. However, in a few cases, the participants were not initially accepted by some team members.

“When I first started, a nurse that was working there wasn’t happy with the peer support position in the place. There was some conflict when I first started there but now everyone on the teams is [aboard].” APS2

For most participants, there seemed to be an evolution in the appreciation of their role by other team members.

“...The team gets used to how I practice and they get used to what the peer role is... Once they become more knowledgeable, they sort of bring clients to me. It's evolved that way and that more people... hit the point of the saturation where everybody knows what I do and how I do it now.” APS3

In this process of evolution among peer support providers’ interaction with the team, there seemed to be a struggle among the participants to justify their role on the team. Many of the participants commented on their role being misunderstood or not valued in the beginning. Participants stated that their role, unlike other healthcare professionals, was the only one that needed a formal outline.

“In the beginning, I tried to prove myself a lot... I feel like I was working against the grain more than I am now... [I] started trying to prove myself because I felt that people weren’t sure what I was capable of doing but I was given a lot of room.” APS1

“... I think there's no other position on the team or in the hospital or in professional life... that you have to define your role... There's a need to justify your role, your

position... A doctor comes in and nobody questions their role. We know what you do and we know what your education is... Whereas a peer specialist, 'Oh we don't know what you do'". APS3

In other cases, participants found that, at times, their peer support perspective was not valued. In these instances, the participants' peer viewpoint was not understood by other team members and therefore, classified as non-essential information.

"...One of the other team members had said we just need to report on what's important, and what somebody had for breakfast is not important. I was upset because there are five or six different designations around that table every day. What the nurse thinks is clinically important is going to be different than what the vocational counselor thinks is important, and what me, the peer support worker, thinks is important..." APS5"

Participants mentioned that many team members perceived peer-activities (e.g. supper club, coffee outings) not to have therapeutic value. In a few cases, team members questioned the time designated for peer-activities.

"When our Rec Therapist has an event, no one questions her use of that time... When I want to do supper club, and I'm on an evening shift... 'Well, who's going to do your job while you're at supper?' It ends up being my supper... There are people who struggle to recognize that there is value in [supper club]... clients aren't just getting a free meal out of it, that there is something peer related about it." APS5

These difficulties were more acutely experienced by PSs. For most PS participants, there seemed to be similar difficulties in team members recognizing the peer support provider as an important role on the team. Most participants mentioned that there were some team members who did not see the value in peer support or misunderstood the boundaries of the role.

“There have been times where there's... certain doctors or staff that I didn't really know how to work with. I didn't feel necessarily like they wanted to work with [me] or that there was any kind of desire or respect for what I bring to the table... It's not so much that it was overt, it was just not a lot of contact and I didn't know how to breach that gap. It's a little bit intimidating at certain times.” PS2

“... Another thing was that [clinicians] asking me to do menial stuff because they don't necessarily think about what skills you bring to the table... [Peer Support Providers] build relationships and... encourage and help people towards recovery and it's not just about monitoring people or helping them with activities.” PS3

“A [team member] is not allowed to call the [peer support provider] and ask what their client has been up to... We have a confidential role... If you'd like to ask them what they've been doing this week, you can ask the [client] that but we don't provide that information... They keep trying.” PS1

In a few participants' experience, they had to maintain a good relationship with other team members in order to receive client referrals. Although this practice was not exclusive to these participants, these two participants mentioned that this element impacted how they interacted with other team members.

“As much as we're supposed to educate colleagues about understanding patients' perspective or being more recovery focused... We often have to work with clinicians to arrange or facilitate our work with clients... because if we're too critical, we may risk alienating clinicians and risk making our jobs more difficult in terms of connecting with the clients.” PS3

“... I'm always going to be there for the client first and foremost, but at the same time I need to maintain a working relationship with the rest of the team, or else I'm going to feel alienated and maybe referrals won't come to me.” PS4

This type of interaction was not visible in ACTT, where all team members shared the case load. APSs did not need to worry about loss of referrals from team members. Most APS participants commented on openly voicing disagreements in discussions concerning clients' health.

“... I butt heads with people a bunch of times. We've had disagreements and I think it comes out of the different origins we come from... You can have disagreements with someone, you cannot be on the same wavelength... but you respect that person...”
APS4

“It's not a yelling or screaming match... For example, last week we had a client who was following up with a Psychologist, and the Doctor was saying, ‘Okay, maybe we should stop the visits for a few months while she's doing that’. And I said, ‘No, no, she needs this, okay? At minimum we should be seeing her at least once a month’. Three or four people piped up and said ‘Yeah, okay’. It's guaranteed we're going to see her at least once a month, despite the fact that [the Doctor] didn't. Now, is it personal? I don't know, it doesn't matter. But someone had to step up and say something.” APS6

PS participants felt more reluctant to voice their opinions than APS participants, as mentioned earlier. Most PS participants commented on how they felt that there was a hierarchy in place, undermining their interactions in meetings as equals.

“... Nurses and Doctors hold a lot of power. And I'm sure there's a lot of transference that go back to my days as a client. But I definitely feel at times... that their decision holds more weight than mine or I have less say in the care of a client because of my role. It can be frustrating, not feeling on the same level as another person on the team. It can be different, it can be alienating, it can be isolating at times.” PS4

However, as seen among APS participants, most PS participants noted that their team members began to gradually understand and appreciate the peer support role.

“... Some days I feel like I’m at the bottom of the totem pole, and in some ways I actually am. But most of the team members will acknowledge the value that talking to someone who’s been there is extremely valuable. I’d like to think that there are times that I keep the team in check... I keep it from a very empathetic standpoint...”

PS4

Once team members better understood the concept of peer support practices, there seemed to be a change in how this role was identified on the team. In fact, when team members approached the APS and PS participants in order to address their concerns, it signified the value of their role to the team.

“I think at the end of the day, the team does recognize that the clients need peer support. I’ve actually had a couple of team members come to me and say, ‘What about this person for peer support of some kind?’... And it’s been the team that’s supported me with that.” APS5

4.2.2.3. Remuneration.

Remuneration is often associated with value and importance of a role on the team. It can also be used to identify the level of education and expertise required to perform the role, which is why some roles have higher levels of remuneration compared to others. Relative remuneration may also be reflective of a hierarchy of positions on the team.

Remuneration was described as a sensitive component in recognizing a peer support provider’s value on the team and in the organization. There were significant variations with respect to remuneration amongst APSs. Some APS participants felt their illness experience was not valued as an equivalent to professional training. Half of the APSs commented on receiving low remuneration for the type of work they did, whereas, the other half indicated receiving fair remuneration or were generally satisfied with their income. Despite this, most APSs commented on remuneration having a correlation with legitimacy and tokenism on the team and in the organization.

“I make about the same amount as housekeeping... It can be very insulting. Especially on those days when you feel like the token crazy person on the team, and someone makes a dismissive comment, or you're not necessarily supported by those around you in the input of the day... I want to be viewed and respected as much as anybody else on the team. It's less of a struggle now, but it's a struggle some days.” APS5

“... If you're paid less than the other professionals, you don't have legitimacy. If you're coming in and saying, 'I have my own mental health issue' and you're getting paid less, you don't have much clout on that team... If I had been paid significantly less, it would just have been a token position... There would have been no credibility, no legitimacy, nothing. But I'm paid on par with the others.” APS8

The level of remuneration, or pay scale, may communicate to the peer support providers and other members that a hierarchy is in place. Participants mentioned that their role on the team equals that of other members. Lower remuneration may indicate that their 'equal' work is not necessarily valued on the same scale as other members.

Most PS participants had low remuneration; they mentioned being at the bottom of the pay scale and feeling that their work was undervalued. Despite this, PS participants did not discuss remuneration to the same extent as APSs. Many PSs stated that their job was fulfilling and found that they could grow in their role if provided with resources and support. Overall, some APSs spoke about remuneration as a significant obstacle whereas PSs commented less on this issue.

4.2.2.4. Dual roles.

Four of the APS participants had a dual role in their peer support provider position with another health care profession role. In all of these cases, the peer support provider had formerly practiced as a designated health care professional in mental health or another health

care field. For a few of these participants, they were paid according to their health care profession designation.

Many of these participants found that they were able to switch their peer support provider role to another when required. In a few situations, if the peer support provider had difficulty with the acceptance of their role, they would have utilized their alternative designation. Two of the APSs stated:

“I think part of the acceptance that I have experienced that I have the privilege of having is that I have a degree in Social Work... I have the clinical backgrounds and clinical education and it's over and above what other people I have worked with have... That's my walking through the front door paper. It's like I'm a welder and that's my ticket. I think that would expose me less to the kind of trying to define and justify my position...”

“... I sort of took the back door to get into my discipline. In a way, it helps me a lot, because when I came in as the peer support worker, the team already knew me for a couple of years... as a nurse... It's a lot easier for them to accept a nurse coming in, than a peer support worker that they don't know much about.”

For a few of these APS participants, it was challenging to determine how much weight they would place on their previous health care background when providing peer support services. In a few cases, the participants tried to follow aspects of their professional degrees, but were concerned about their role boundaries.

“...It is really difficult to define [the peer support provider] role... I'm under the College of Nurses. One of the requirements with the College of Nurses is that you do not talk about your personal life, you don't disclose private information with patients... But as a peer specialist, my job *is* to disclose my personal life and talk about it with clients, when necessary. I'm in both roles, but I have to go against one to do the other... So that's a grey area.”

In this case, the APS resolved this ambiguity by using his/her intuition to see what would help the client.

“I just do what I think is best to do for the client at the time. If that means telling them a bit about my story because it’s going to help them, maybe give them some hope, or help them feel a little bit more at ease with themselves or acceptance on the team, then I do that.”

Additionally, this APS prepared their letter of employment offer in case their College required approval of their role on the team. The APS commented on having his/her employer’s support if the College asked for details. Despite this preparation and attempt to solve the ambiguity, the APS suggests to define the role based on what the peer support provider believes is beneficial to the clients.

In some situations, when participants had difficulty adapting to the peer support provider role, they would engage more in their clinical expertise.

“I kind of struggled initially, I think partially because of the lack of specifics... What part of my brain am I going to be using? I was going to apply [to a RPN position] because I still didn’t understand my [peer support provider] role... I’m the only peer support worker in the [organization], and I didn’t know if it would be relevant, if it was going to be part of the skills I would need, and if the [organization] was going to support that.”

Participants with clinical backgrounds did not require additional clinical training and could focus on their generalist role right away. As noted earlier, APS participants with a lack of clinical background had to learn clinical language and practices to engage with team members.

These dual roles were not experienced by PS participants. Only half of the APS participants experienced this duality in role enactment, with varying degrees to how it impacted their role development. This dual role in most cases assisted the APS participants in integrating to teams, mainly into their generalist roles. This duality also seemed to assist a few APS participants in having their voice recognized on team due to their underlying professional designation. Overall, for some peer support providers, a clinical dual role may enable their facilitation into their role.

4.2.2.5. Disclosure.

Disclosure was a common topic among the participants. In particular, two issues regarding disclosure were mentioned. The first referred to determining the type of information that would be disclosed to team members about the peer support providers' own recovery journey, and the second referred to determining how much information to relay to team members about conversations with clients.

The first type of information disclosed to team members concerned the peer support providers' own past experience of illness and recovery. This type of disclosure was regarded by all participants as an important component of their role. There were variations in how much information the peer support providers disclosed about their recovery journey to team members. Overall, however, most participants expressed the need to speak of their past illness when they wanted to advocate for their client's health and needs. In most cases, both APS and PS participants commented on using their illness experience to encourage their team members to take on an alternative perspective.

“...Peer support worker is a role where you have to be comfortable in disclosing information about yourself to clients and sometimes even have to share with staff. For example, say I’m in a meeting and it comes up that a client is not happy about taking medication or getting injections... I can say I’ve experienced that and reflect it back to the team and that’s part of the role of peer support. Sometimes I feel that you’re advocating for the client and... you’re also educating the people on the team as well.” APS2

Only a few APS and PS participants commented on feeling vulnerable or insecure when disclosing their illness experience to team members. A few participants felt judged by team members who were aware that a requisite to the peer support provider position was experience with psychiatric illness.

“People who work will be quite aware of your psychiatric history and whether you divulge that, which I don't or selectively with people I trust... People are aware and most people you interact with are aware of the psychiatric history... You're always wondering whether something that was said or details of a conversation are a reflection of how the person you're speaking to is judging you because of your psych history.” PS3

In these cases, participants revealed their feelings of insecurity with respect to their interactions with team members.

There were a few cases in which team members had difficulty understanding the boundaries regarding the sharing of client-related information. This misunderstanding usually arose due to the team members' misconception that the peer support role was to act as an information liaison. Most PS participants discussed that they only shared relevant health or recovery goal information about clients to team members due to the confidential relationship between the peer support provider and client. There were variations with respect to how much information was shared. When they needed to advocate on behalf of their clients, the PS and APS reported that they would use their clients' general perspectives rather than specific details.

“... I don't always share details [with team members]. I will share [the clients'] perspectives or some of the things. If I find something that they've shared with me is really relevant, then I will bring it up, but only if it serves to advocate for their needs or for their rights in terms of the care that they are receiving.” PS2

Despite this, in extenuating circumstances in which the client's health was at risk, the APS participants did refer to information about their clients. APS participants did not comment on any restrictions in sharing information about clients with team members.

For most, there was no significant difference in how much information peer support providers disclosed to team members about their illness and recovery experience. The peer support providers made the decision as to how and what type of information they shared with their team and mainly discussed this information when they deemed it beneficial to their client's care.

4.2.2.6. Stigma.

All participants spoke about the stigma associated with their illness experience. Most participants discussed this stigma with respect to their personal and professional lives. Both APS and PS participants spoke about experiencing stigma during their illness and while providing their services as a peer support provider. Although the participants perceived stigma to be coming from individuals outside their team, a few did note they felt stigmatized by their team. In these cases, both APS and PS participants commented on sensing varying degrees of stigma when providing services as peer support providers. PS participants perceived higher levels of stigma from staff members compared to APSs.

Two forms of stigma were mentioned by APS and PS participants: overt and subtle. Examples of overt stigma include open vocalization or actions of discrimination against peer support providers by staff members within the organization.

“[An organization staff member] said, “You can't be both the worker and someone who has a mental illness. You can only be one or the other.” And basically, by implication, since I'm someone who has a mental illness, I can't ever be a worker... Other people will ignore you when they see you coming. They will shuffle off the other way, they will avert their eyes, there's more discrimination than people think... We have an eating area at [the organization]... I'll come in, and that person will put their sandwich away and go out. Like I said, it's a reality.” PS1

In other cases, participants commented on feeling subtle forms of stigmatizing by staff members. Some participants noted that some cases of subtle stigma may be due to the staff members' lack of experience or education rather than an attempt at intentional discrimination.

“... I'm not really sensitive about these things because it can come from a position of ignorance, and I don't mean ignorance in a malicious way. People not knowing any better or not being educated about it... My team is being pretty good... It's not as much the team now, but it's much more people in the wider institution.” PS3

“... [Human resources staff member] referred to our [peer support provider] jobs as volunteer, and my colleague corrected her and she did it twice during the discussion. It kind of reflected our feeling that we aren't often viewed as equals by our colleagues.” PS3

Some participants felt a sense of stigmatization when they first joined, however, this feeling dissipated over time as they integrated into their team. For example, one APS decided to take on more work to challenge the APS's perceived 'token' position on the team. Taking on a more active role within the team helped the peer support provider in challenging preconceived notions of peer support providers on the team.

“Peer support workers and specialists do not normally take on call [but] I take on call. I want to be a full-fledged member of this team. I don't want to be the token, and there have been moments where I have felt very much like the token... I was once asked by a peer of the team... ‘What was I doing here? Our last peer support worker just went shopping and didn't really do much, and we liked it that way.’...” APS5

Most participants discussed how they directly confronted their team members and organization staff regarding their discriminating comments in order to foster an environment of zero-tolerance.

“...I was on an in-patient unit a couple of months ago and there was a nurse being quite derogatory when talking about the client. I think some people, it might have not bothered them as much, but it really bothered me and so it ended up with me filing a complaint. If anything, I think the stigma actually makes me want to do my job better... for me it's good to sort of keep a finger on that and remind people that it is stigmatizing. I did a whole presentation on stigma and stuff.” APS2

Although stigma was identified as an obstacle for many peer support providers, most participants commented on developing an understanding with team members to challenge this perception. APSs generally spoke about being able to discuss stigma with team members. For instance, an APS discussed their strategy to use humor to open the discussion on stigmatization with team members in order to foster a sense of cohesion among the team.

“... I think that stigma comes in humor... but I make jokes about my own sort of experiences and it's always well received. We laugh about it and I think that's probably one of the best markers. It's because humor can be so subtle, right? There can be ‘negative’ humor and there can be ‘positive, everybody laughs about it and feels good about it’ humor. We have a lot of the latter on the team which really shows a cohesive team.” APS3

Some of the APS participants spoke about experiencing internalized stigma even with an absence of external stigma from their team or staff members. APSs vaguely commented on these experiences brought on by reminders of their negative experience as clients within similar organizations, or by seeing similarities among clients.

“... There are some things that might bother me more than other people, where they might tolerate it... The fact that there is stigma and I know clients are stigmatized

too. I think people really forget about how stigmatizing it is to have mental illness on the team sometimes, like going to the hospital, that's a stigmatizing experience” APS2

“... I haven't personally encountered anything when I've met with other professionals, I haven't encountered anything like that. I see a lot of self in the clients, the feeling that they've got a sign printed across their foreheads, everyone knows it...” APS8

Participants had varying experiences with regards to stigma with team members and staff. In most cases, participants found support from team members and often faced difficulties with other staff members.

4.2.3. Relationships with clients.

A prominent component of the peer support providers' role is to engage with clients on a meaningful level. In many cases, peer support providers are able to engage with clients in a manner that is different from other care providers due to their ability to draw on their past experiences of illness when advising and helping clients. This peer support provider-client dynamic is composed of different elements, including terminology used by providers to refer to clients, types of interactions, and level of personal illness disclosure.

4.2.3.1. Service user terminology.

The organization or team often designates service user terminology. Depending on the types of services provided, the receivers of the services may be referred to in different terms. When discussing service user terminology with participants, most individuals in ACTT referred to service receivers as 'clients'. This might primarily be due to the ACT Program Standards, where service receivers are referred to as 'clients'. However, there was a variation in terminology used by APSs when referring to receivers of ACTT services, ranging from 'service users' to 'persons (people)', and 'peer'. One APS commented on identifying the client based on what health service they were using.

“If [service users] live in long-term care, they reside there, they’re a resident. If they live in the community, they can be a client. If they’re in hospital, they’re probably a patient. It changes depending on where you are in your health.” APS5

Other APSs discussed using the term ‘person’ or ‘people’. PSs were similar with respect to the terminology they used to refer to service users. Most participants commented on using ‘clients’ when discussing with team members, and ‘peers’ or ‘persons’ when speaking with service users. Despite the similarities regarding the participants' use of service user titles, many noted the challenge of reaching a consensus over the terminology used to refer to service users.

“... I don't mind consumer, survivor, or peer. They're all, to me, saying the same thing. Whereas some people do have a challenge, because is it a trigger for them, using one word or the other. The problem is technically, no matter what word you use, there's going to be someone that has a difficulty with it. There's no one accepted word.” PS1

Most participants found the term ‘client’ to be acceptable for use in discussing with non-peers and health care professionals. In this paper, the term ‘client’ has been used as a standard term.

4.2.3.2. Disclosure and boundaries.

Peer support providers provided services in either a group setting or on a one-on-one basis. In many cases, APSs discussed how they followed a self-made guideline with regards to the circumstances in which they disclosed their role to clients. Over time and with practice, APSs were able to develop the skills that allowed them to better disclose their lived experiences with clients. Peer support providers commented on being able to stretch their boundary with clients to be more flexible than other team members who are regulated by professional Colleges. Thus, what may be appropriate for a peer support provider, may not be appropriate for other team members.

“In general, I disclose a lot more than any of the other team members... I use my personal cell phone, and it's not blocked, and [team members] keep bugging me, ‘You should block it so [clients] can't get your number, they might call you back’. I said ‘No’. That's my job and I don't mind, and I'll deal with it if it becomes a problem... In another instance there was a client who was having a bad time, she was crying, and I gave her a big hug. Most of the team can't do that because it crosses the boundaries... I can get away with a little bit more in that respect than most of the other team...” APS6

Most participants commented on clients having a closer relationship with them compared to other team members. For most APSs, there seemed to be a more flexible role compared to the other team members.

In the case of PS participants, clients were briefed on PS roles before their first meeting by other health care providers who refer the clients to the PS. Although, clients usually shortly introduced to the title of the role, most did not understand what the role encompassed. Most PS participants spoke about introducing their role right when they met with the client. In doing so, some participants commented on drawing a parallel with the client about similarities in lived experience.

“Whoever is referring [the client] to me will always say ‘I just have someone I would like you to meet’... I think there's a lot more power in me saying to the client, ‘Here's what I've been through’. That's something that I definitely disclose to all my clients... I received care in a place just like this, and I'll try to draw on parallels that I have with the client... it can strengthen the relationship between me and that person.” PS4

However, there were some participants who chose to only disclose their past illness experience when it benefited the clients. This was similar to APS participants. There were different responses noted when the APS would disclose their role to clients. In most cases,

participants commented on not disclosing details about their lived experience until they found the client was further in their recovery.

“... The only time I will disclose is when it benefits the individual. If it's the first day I meet them, I'll disclose it the first time I meet them. If it's never, I will not disclose... Even if you say peer support worker, it will not click with some people... Depending on what kind of response they provide, then it'll totally depend which way I go... I will not disclose unless I know it benefits them...” APS4

“We had a client who was relatively new... When I went back to see him the third time, he'd made some comments that people don't understand how hard it is and all that. And I said, 'Well I'm so glad that I'm the one who got to come and see you today, because I wanted to tell you more about my job on the team'. So it worked out beautifully... I felt really rewarded and he felt very comfortable, because we weren't those know-it-all nurses. I get it, I get what it feels like.” APS5

Most APSs discussed boundary as an important element in their interaction with clients, however, PSs often commented on developing a boundary together with clients. This was not commonly seen among APSs, which may be due to the ACTT model where the APS is considered a member of the team of service providers. Whereas, in non-ACTT, it seemed that PSs were able to develop a more reciprocal relationship with clients, with boundary development from both sides.

“...First of all, boundaries for peer support workers aren't going to be the same boundaries as professionals... Peer supporters don't want to have a hierarchal or a therapeutic relationship. We're about having this relationship, where we are both benefiting and we are both giving and receiving. Which is very different from a professional, because the professionals give, they're not supposed to be receiving... Setting a boundary and a limit, is within the relationship... In peer support, it's about the relationship and the two people together.” PS1

Most PSs commented on holding a confidential relationship with clients, in which PSs did not disclose information concerning the client unless given permission by the clients. PSs mentioned that they had the authority to relay information, if needed, but chose not to do so in some situations to conserve the trust in the relationship.

“I tell all the clients that I see that ‘I do have the right to tell other members of my team anything you say, but it doesn't necessarily mean I will’. I do hold a confidential relationship with each of the clients that I see, because I think it's extremely important in a trusting relationship... If I do tell the team something that [the client] didn't want me to, it could fracture the relationship... I think healing can only come if there is trust and reciprocity.” PS4

In one PS participant's experience of boundary development, the client and peer support provider came to an agreement on boundaries concerning medication compliance and information relay to team members.

“A client was prescribed an antidepressant, and he did not want to take it... He had confided in me that he tried it for a week, didn't like it, so he stopped. He said, ‘I don't want you to tell the psychiatrist or nurse, because they'll just get mad at me’. And I said okay, so we went through all the risks of not telling the psychiatrist because it can be dangerous with taking half a dozen other medications, there could be problems. But in the end he still felt that he wanted to keep that private, and so I respected that.”

The PS participant mentioned that soon after, the client informed the other team members of the decision to stop medication use. The participant concluded that he/she would have informed the other team members if it affected the client's health.

However, there is always a danger that the relationship may become too reciprocal, with boundary lines becoming blurred.

“What often happens is a client will connect with me extremely well because we are having a much more natural relationship. And they just simply don't connect with their nurse or doctor, and so they'll only want to deal with me. In the psychiatric world, you would call that ‘splitting’, because now they just want to talk to me and only me. They'll tell really important stuff to me and now all of a sudden all that responsibility falls on me.” PS4

In these situations, the peer support provider must maintain a boundary or else the client will engage in ‘splitting’ where they will only talk to the peer support provider about their problems. To resolve this situation, the peer support provider needs to be able to recognize if ‘splitting’ is occurring so that they can involve other team members to prevent it.

The blurring of the boundaries can be illustrated in other circumstances as well. For example, in one case, a participant commented on the boundary lines blurring when the client invited the peer support provider to a family event. The participant reacted to the situation by clarifying boundaries.

“It would be very easy for me to ... develop an actual friendship outside of work. But I haven't. And I do have to explain to [the client] that there are boundaries there, and in doing so, you can feel [the client] pull back just a little bit.” PS4

Most APSs and PSs commented on their role being well-received by most clients. Some participants mentioned that their role as a peer support provider gave hope to clients for recovery.

“I've actually had clients say to me 'I'm really proud of you, look how far you've come, look what you have done'. After I've shared a story or told them... they are like 'Oh, wow, it really makes me hopeful' ... In the client base, I have found that the acceptance has been there.” APS3

However, participants mentioned that they need to pay attention to how they portray themselves to clients and their families. If peer support providers use themselves as examples of recovery, they might raise expectations too high for clients and families.

“I don't like using myself as an example because I do realize my symptoms and experience has not been as intense as [clients] who end up on an ACT team. I don't want to get their hopes up too much to say, 'Oh this is going to be a recovery and we're going to have this fun'. Some people will never be able to achieve that level of function, but they are capable, with recovery-oriented services, to achieve the best level of functioning they can.” APS3

In some cases, APSs explained that some clients reacted negatively to the disclosure of their lived mental health experiences. APSs described encountering clients who did not want to receive services from a team member with past illness experience. In most of these cases, this reaction occurred at the time of disclosure of peer support role to client.

“I remember in the early years, I just thought that I should tell people and whatever... Once, one of the clients was very unwell, phoned the office and said ‘Don’t send me the crazy worker, I want a proper worker, this one is crazy’. Because I told her I was a peer specialist and I explained what that meant and everything and she went berserk.” APS1

“... When I first started, I told [a client] I was a peer support worker, and I was hired as being a model and all that. The person said, ‘Good for you’. That was the way she answered. And we, [team members and I], laughed about it afterwards, because... she didn't have anything to learn from me.” APS7

Such negative experiences taught the APS participants how to effectively disclose their role status to future clients.

In addition, APS and PS participants reported that some clients were not interested in the peer support services. Participants hypothesized that this may be due to several reasons, including denial of illness, lack of interest in peer support services, discomfort in interaction or inability to connect, and Court Order Treatment (CTOs). The last reason is often seen in ACTT where some clients may be court ordered to receive treatment. APSs explained that individuals with CTOs do not often comply with ACTT services and may refuse peer support services. Both APS and PS participants explained that they tried to engage difficult clients to a point, but would avoid pushing to the point that would create an uncomfortable situation.

4.2.4. Interaction with external groups.

Peer support providers interact with a wide range of health care providers and organizations as part of their role. In addition, they would often engage with members of the community to assist clients in accessing services. The participants discussed their interactions with two different types of groups: non-peer external groups and peer groups.

4.2.4.1. Interactions with non-peer external groups.

Non-peer external groups included health care providers in other organizations (e.g. hospital, clinics), transportation service providers, lawyers, community resource centres (e.g. food banks), and in some cases, family members of clients. Both APS and PS participants stated that this interaction was beneficial to create local community contacts and foster a bridge between clients and service providers.

APSs explained that their interactions with other health care professionals in hospitals were mainly to check up on their clients' statuses and see if they were admitted. Some APS participants commented on receiving positive feedback from external health care professionals when they learnt about the role.

“... I've introduced myself to other doctors or health professionals at different hospitals and places, and they either don't know what peer support is or that there is such a thing as an ACT team. They go, “That's a great idea, you're doing it with the

hospital. That's awesome, we love that.” I've gotten the exact opposite of stigma... A lot of them are welcoming. That's been the vast majority of my experiences so far.”

APS3

However, in most cases, APSs noted that external groups did not recognize the peer support provider role. Participants explained that these external groups may not necessarily be aware or educated on the role.

“Honestly, I'm not always sure if everyone necessarily does understand. Probably not. They know I'm a worker and I'm supporting, I'm working on behalf of the certain individual and that's probably all they care.” APS4

In some cases, APSs encountered difficulties when engaging with external groups. Participants described their experiences being denied information concerning clients or not being acknowledged as an ACT team member.

“Once or twice I've actually turned my nametag around. My nametag just says peer supporter but I've turned it around because I've felt dismissed because of that...”

APS5

“There's the community [transportation] services for when I organize my groups. I sent them the information and the person questioned the fact that we were doing something ‘medical’... He questioned the fact that I was a peer worker and there was no doctor there for the group...” APS7

These situations were often resolved when the participant's team members contacted the external organization to confirm their role on the team.

“I brought [the issue] to my team and my team leader wrote a letter explaining how our services worked, and she mentioned the peer support worker is like everybody else on the team. And she sent that in.” APS7

In one case, an APS participant had to use their dual role as a social worker to retrieve information about clients. The participant commented on if he had approached the health care professional with the peer support provider role, he/she would not be recognized as an equal on the team.

“I was at the [health care organization] and I needed to see a client... I happened to have time that day and I tried to get information for this client and the doctor refused. He said, ‘I’ll talk to the doctor’, and I’m like, ‘Guess what? I’m a social worker’. ‘You’re a social worker? Go talk to a social worker in the hospital’. I talked to the social worker in the hospital and... I got information on this client... If I had gone in there and said a ‘peer specialist’, they would definitely not give information to a peer specialist...”

Most PSs had no difficulties when working with external groups, which was similar to APS participants. PSs tended not to interact much with individuals outside of their organization, since there was no need for it. However, some of the PSs commented on developing community networks to support their clients. For example, one PS developed a working relationship with a local youth centre to introduce resources to clients.

4.2.4.2. Interactions with peers.

The second type of external group mentioned by most APS and PS participants was peer-run organizations and peer support providers. Most participants mentioned accessing peer support resources from their local peer-run organizations. Participants commented on finding these resources as an asset in providing their peer support services. Most participants found recovery-oriented training available from these organization and commented on positive experiences in interacting with them. However, some APS participants encountered discomfort concerning interactions with non-ACTT peer support providers. This discomfort was brought on by misconceived perceptions of some non-ACTT peer support providers concerning the role of peer specialists on ACTT teams. One participant identified this attitude as ‘more peer than thou’. The participant explained that some non-ACTT peer

support providers believe the ACTT model to be coercive, and in turn going against peer support values.

“I have run into it a presenter... this is one of the top players in developing peer support in Canada... and she said, ‘Well ACT workers aren't peer support workers because the ACT model is coercive’... Again the more peer than thou attitude.”

Participants mentioned that some non-ACTT peer support providers believe their services are much more peer-oriented than ACTT peer support services. In some ways, participants felt that they were seen as moving away from the peer support ideologies.

“When I first started working on the ACT team, [peers] were like ‘Oh, you work for the hospital’. Kind of like, not so much of a traitor, but you’re working with them... Over the years, I have made an effort to go to [peer-run organization]... I’ll bring clients to show them the drop in. I think part of the rule as a peer support worker is that we’re sharing all these resources that people in the team aren’t aware of.” APS2

One APS explained how there were different forms of peer support and that ACT peer support would vary from other formats but that the difference is not in ideology but in implementing it within the available context.

“... You get some peer support that work for the community, and they don’t generally agree with the rule of a peer specialist on ACT. They feel as if you are enforcing treatment on someone who doesn’t necessarily want it. They say that you’re not a true peer specialist if you do that, but again at the same time, there are different kinds of peer support specialists... There is a real benefit to ACT having peer support and I think more people who work in another type of peer support, such as a non-clinical setting, are basically seeing the importance of a peer specialist role.” APS2

Although, PS participants did not comment on the ACTT model or APS participants, they did share similar views concerning positive experiences with peer-run organizations. Most of the PS participants interacted with their local peer-run organization to access peer support resources and training. Both APS and PS participants commented on how these organizations provided an opportunity to grow communication and support networks amongst the peer support provider population.

“My self and some of the other peer workers have talked about trying to connect more often and find more ways to get together and collaborate. I've been talking to people from [peer-run organization] who are starting to get more and more involved in some of the peer stuff in different hospitals and mental health facilities... I have my own support network but to be supported by other people who are doing peer work is also important in the same way in any profession that has a professional organization. You get together with other people who do the same job as you so that you could bounce ideas off and mutual support.” PS2

Despite the negative experiences of some APS participants, there seemed to be a positive view concerning the value in the relationship with local peer-run initiatives.

4.3. Summary of Factors Influencing Integration of Peer Support Providers

The process of integrating a role within a team is often challenging, integrating a newly developed role would presumably be even more so. In the case of peer support providers, this study observed the types of obstacles and enablers faced by participants in their integration on the team and in subsequent work. Tables 5 and 6 respectively provide a summary of obstacles and enablers reported.

Table 5: Summary table of obstacles reported by APS and PS participants		
1	Lack of training & educational resources	Lack of training concerning clinical documentation and terminology. Peer support providers did not receive sufficient training at organization.
2	Limited funding for peer support activities	Mainly commented on by APS participants who felt limited resources to be an obstacle to providing their services to clients.
3	Low remuneration & hours of employment	Low salary in comparison to work; lowest paid member on the team; lived experience not recognized as training.
4	Isolation on team	No other peer support providers on team or in organization; difficult to find other peers with whom to exchange information. Some PSs reported not being able to actively voice their opinions on the team in fear of alienating the clinician team members.
5	Peer-persona/ Peer support provider seen as a token position	Lack of education among team and staff members about peer support can cause misunderstandings about the peer support provider role. Stigma concerning the peer support provider role may be brought in by team, staff members, and external groups. Inequality of role membership on team; peer support providers valued less than other team members.
6	Role Ambiguity - Lack of job description - Peer support provider confusion on how to assess peer support outcomes	Lack of role clarity creates confusion among peer support providers and team members regarding responsibilities and boundaries. Need to constantly justify role on team if it is not accepted or understood by team members. Peer support provider may also require some structure to report peer support-relevant outcomes in clients. Difficult to report outcomes using standard team outcome tools. PS participants reported doing activities and tasks that are not representative of their peer support role. Lack of job description may lead to ambiguity about the peer support provider role.

There were six main obstacles reported by most participants, however, three of these obstacles had additional comments by APSs and PSs. The first obstacle mentioned by APS participants specifically, included lack of resources preventing participants from facilitating programs for clients frequently. Some APS participants commented on team members not accepting the time set aside for the peer speciality in facilitating these events.

Isolation on team was reported by most APS and PS participants in terms of the lack of contact and presence of other peer support providers in the team and organization. PSs also added to this obstacle by referring to their reservation in voicing their opinions on the team. These participants mentioned they had to be wary of what they said around team members to maintain their relationship for future client referrals.

Another obstacle commented on mainly by PS participants included the addition of non-peer related tasks as part of their role. For some PSs, administrative tasks were added

onto the role after joining the team. In the case of APSs, most participants had been aware prior to joining the team about their generalist and speciality role, whereas PS participants came to find out after joining the team.

Table 6: Summary table of enablers reported by APS and PS participants		
1	Team and organizational support - Funding resources - Organizational education of peer support	Receiving support from team members and interest from organization assist peer support provider in developing their role. E.g. More resources to develop the peer support provider role.
		Organization educating team and staff about peer support helps create a recovery-oriented outlook and challenges stigma concerning mental health.
2	Network development with peers and community members	Participants commented that network development among peers prevented isolation. Interacting with local peer-run initiatives assisted peer support providers in exchanging information and contacts.
3	Training	Participants commented on lived experience as a type of training for their role. Peer support providers use their own experiences to connect with clients and relate to team members about issues. Additionally, peer support and recovery-related training helped peer support providers facilitate more activities.
		APS participants commented on transferring skills from their previous clinical role to their peer specialist role on ACTT. In most cases, the dual role assisted participants in adapting to the generalist role.
4	Job description	Vagueness of job description enabled some participants to explore and define their role with more flexibility.
5	Certification	Participants viewed certification as structuring and legitimizing the peer support field. It is a forum for peer support providers to meet and discuss new approaches to peer support.

In addition to the six obstacles, participants were clear in mentioning five enablers to their integration on the team and subsequent work. There were similarities among most APS and PS participants' views of enablers. However, APSs had an additional comment concerning training as an enabler. As mentioned in earlier sections, some APSs relied on their past clinical education for their current role.

Overall, participants responded similarly on obstacles and enablers to their integration into teams. By taking a closer look, we can see some differences among APS and PS participants on the types of obstacles and enablers they faced. These differences may be a result of the variation in program models.

4.4. Implications of Peer Support Provider Role

Integration of the peer support provider role in the team impacted three main groups: clients, team, and peer support providers themselves. Participants were asked to comment on the implications of their role to each of the groups, and to indicate these were benefits or negatives to the proposed group. Table 7 summarizes the overall perception of peer support providers concerning implications to the clients, team members, and themselves.

Table 7: Summary table of benefits and negatives reported by APS and PS participants

Clients	
Benefits	- Clients engage with someone who has gone through a similar process. - Clients have options to choose from different therapies introduced through peer support. - Peer support providers are able to advocate for clients, educate them, and foster hope for recovery. - Clients develop connections with the community and are assisted in navigating the system.
Negatives	- Peer support may not have an effect on the client or client may not be in a place to accept peer support. - Majority of participants said there are little or no negatives to clients receiving peer support. - Peer support providers need to be careful not to foster false sense of hope or recovery. Reminder that recovery is different for each person. - Blurred boundaries may impact the relationship between peer support provider and client.
	Reported by APS: - If peer support provider becomes sick, they will be unable to attend to clients. - Some clients do not connect with the peer support provider or engage with them due to stigma concerning lived experience.
Team	
Benefits	- Peer support provider can bring up perspectives that other team members might have missed. - Provide a perspective on different treatment options for team members. - Engage with clients in a way that other professionals cannot. - Provide an alternative mentality to the current mental health system - provide a humanistic approach and remind team members that they are working with a person rather than a client.
Negatives	- Team members may not be comfortable with aspects of the changes brought on by the peer support provider. - Offering additional options may result in team members having to take on more work.
Peer Support Providers	
Benefits	- Peer support provider takes lived experience and turns it into a positive notion to help others. - Improvements in clients' health is rewarding experience for peer support providers. - Gain confidence and ability to represent voice of clients.
Negatives	- Subtle stigma and lack of acceptance by team create a stressful environment for peer support provider. - Some discomfoting interactions with clients may be negative triggers for peer support providers' health. - Isolating experience for peer support provider as being the only one on the team. - Feel undervalued due to the hours of employment and level of remuneration.
	Reported by APS: - The peer specialist experience may not be useful or relevant if going into a different career. - Role can be stressful when clients pass away or are injured. - Peer support providers may require medical services and time off. This can happen to peer support provider at any time and therefore, is difficult to predict when they will require time off.

Comparing both APS and PS responses, there seemed to be little difference concerning the perceived implications. Most of the differences may be attributed to the different models.

4.5. Certification

Peer Support Certification and Accreditations Canada (PSACC) was an area of interest in this study so peer support providers perception of certification was explored. Both APS and PS participants were asked to comment on their thoughts concerning certification of peer support providers in Canada and its implications to themselves, clients, and their health care organization.

4.5.1. Implications of certification for peer support providers.

Most APS and PS participants felt positive about PSACC and its implications to peer support providers. About half of the participants were aware of the certification process and its long-term implementation plan across Canada. There did not seem to be any major differences amongst APSs and PSs in their view concerning certification. However, there were a few participants in both of the groups who did not feel comfortable with the concept and wanted more background knowledge before supporting it.

There were variations among participants' thoughts concerning how the certification would impact their current peer support provider role. For some participants, the certification would help the peer support provider role become legitimized and credible among health care professionals. For many, the certification was viewed as a tool to structure the ambiguity of the peer support role and help others recognize it as a valuable entity rather than as a token.

"I think it would only impact my practice in the sense of being able to provide that education and credibility to other service providers in a more available way. Go to the website and check it out kind of way; that would establish greater credibility. Actually affecting my... day to day practice, I don't think it would change all that much... I think it might give us more of a common basis for more interactions with

conference... I think they would impact my practice in that way of having less isolation.” APS3

“Yes it would impact my service delivery... There are still days where I feel like I'm floundering. ...where I don't know what the hell I'm doing. Moments where you feel unstructured, unguided, and there are days where you get the two clients, and the drawing, and it is bang on... with certification, it'll give me more tools to do that again... There are people I think who need to recognize that it's an entity, it's not a casual token position... There are standards, guidelines that must be met.” APS5

“It's fantastic. I was thrilled when I found out that we were an accredited service. Because it adds so much, it adds accountability, a standard of practice. All the things that go into making peer support a real profession. Because right now we're kind of trying to find our way. Certification is gonna go a long way into making this an actual discipline where people can study it in school and, where it's recognized as a real profession. It's a career.” PS4

In other cases, some participants felt that the certification would not be useful to them due to retirement plans or because of their well-integrated position in the team. A few participants brought up the need for further testing and research prior to accepting its implementation. One participant in particular found the cost to be an obstacle in approaching certification.

“... Until there's more known about it... I don't know how I'm gonna really take it. I always have a little streak in me that's a little bit concerned about codifying or normalizing or enshrining peer support, because it is grassroots as well. I'm not actually per se against certification, just what does that mean, what is it about, and will it really accomplish what it's supposed to? I mean it's probably going to cost a couple of thousand dollars. And let's be honest, how many peer supporters can afford that?” PS1

An APS participant also brought up the idea of which forms of peer support on the continuum should look into certification. The participant commented on how mainly peer support providers in ‘credential driven bodies’ would require the certification.

“I think peer support operates on a broad spectrum. I think [the certification is for] people who really want to refine their skills in helping and work in a specified role, I think it's also the environment. I think it's the push because [peer-run organizations] have been doing peer support for decades and nobody is saying you need a certification... It's only because of the presence of peer support in institutions, government, military, hospitals, and these are credential driven bodies... I think it's grown as far as it can into consumer survivor initiatives which is good but to go beyond that into these other institutions, then the accreditation is necessary.” APS3

Most APS and PS participants suggested that they would get certified if they had the resources and information regarding the process.

“If it was available I’d take it for sure. I have no problem there... if it was available and the [health care organization] was willing to provide for it, absolutely. I have no problem there.” APS6

“I'm definitely thinking about it, it's been really insightful. I actually didn't know a lot about the certification process before the conference or even actually until I had a conversation about it with my manager. She was like, ‘Does this mean that you're gonna be certified when you go to the conference?’ I'm sort of interested in that but also interested in knowing more about it before I fully pursue it.” PS2

When asked about their views regarding other peer support providers’ reactions to certification, most responded that they would respect the opinions of other peer support providers. A few participants commented on how some peer support providers may have additional obstacles to certification, which may lead to their decline in support for the certification.

“...In my opinion, especially now that we are going through this accreditation and certification... There is going to be growing pains but I really still think we need to really support each other and be there for each other... I need the other peer support worker roles to keep me accountable and credible and help me what I can be in that position and role... They don't have to agree with me all the time in that way but I hope we don't start tearing each other apart in that regard.” APS4

“I think peer support is less about a little plaque on the wall and more about a person with lived experience, and who's willing to share that with someone else... Not all peer support workers are cut out for school or classes, or depending on how long or difficult the course was... A lot of [peer support providers] wouldn't be able to do that. I personally wouldn't judge it more or less whether they had it or not.” APS6

However, a few participants felt that it would be beneficial if peer support providers supported certification.

“I think that the truck is coming down the highway, you can either stand in the road protesting it and get hit by the truck or you can get in the driver seat and start driving the truck. Either way, you're going down the road. It's coming down the pipe and you can either be one of the people that's getting behind it or getting run over by. That's my basic take on that.” APS3

4.5.2. Implications of certification on clients.

Most APS and PS participants commented on certification not impacting clients and their perception of peer support providers. In most cases, participants mentioned that clients would be more interested in the help offered rather than in seeking out their peer support providers' credentials.

“... I don't know if it would really make a difference to them. I think generally when somebody is in crisis or needs hospitalization or needs services, it's more like what can you do for me? ...Most clients, from what I would gather, would want concrete

production of something, 'Hey, can you get me bus tickets, I need to go to the mall to see the doctor or whatever' than a piece of paper that says I can do my job. They would rather know you can do your job.” APS3

4.5.3. Implications of certification on organization.

Certification and accreditation is often a feature that health care organization uses to identify how well health care providers follow milestones and goals. This feature is often used to provide credibility and legitimacy, to display that certain standards been met. Some participants mentioned that their organization and team managers had already been informed of this certification process and were thrilled to look into it. This type of approach to certification may be seen as an enabler for peer support providers in accessing certification resources (e.g. financial assistance for certification).

“I don't know everywhere else but we're pretty big on certification. It doesn't always mean you could do a better job but since it exists for other professions. It wouldn't hurt us to have that...” PS3

However, in some cases, participants mentioned organizations requiring more concrete information prior to confirming their support to certification and accreditation.

“I've been involved a little bit on the periphery of [health care organizations] looking at peer support. They are afraid of them.... Afraid is a bit of a strong term but they are uncertain about it. They are uncertain about the evidence-base... They want to know more about it to be able to get behind it and go in this direction with our funding and creating positions... It's a credential driven institution. It will go a long way to saying this person is qualified, educated, capable, and competent to deliver the services that you're talking about.” APS3

Overall, there were mixed responses concerning certification. Reactions need to be explored in the future, after more research on the long-term impact of certification is conducted.

5. Discussion

The findings presented in the previous section outline several dynamics related to the integration of peer support providers in ACTT and non-ACTT models. Several themes were discussed, including the peer support providers' initial experiences upon joining the team as well as their interactions with team members, clients, and external groups. Additionally, the concept of certification was examined. This study has found evidence to support several conclusions made in the literature regarding peer support service delivery and integration, while also presenting new information regarding factors influencing the integration process. The study confirms previous findings regarding factors influencing integration, including: Lack of training and education resources (Gates and Akabas, 2007; Moran et al., 2013; Solomon and Draine, 1996), low remuneration and hours of employment (Walker and Bryant, 2013; Moll et al., 2009), isolation on team (Moran et al., 2013), blurred boundaries when relating to clients (Mowbray et al., 1998; Carlson et al., 2001; Gate & Akabas, 2007), role ambiguity and lack of job description (Gates and Akabas, 2007; Moran et al., 2013; Repper and Carter, 2011; Solomon and Draine, 1996; Walker and Bryant, 2013).

In addition to these findings, my study adds knowledge of peer support providers' perspectives on developing relationships with team members, boundaries with clients, and potential challenges and enablers to integration. While examining the literature on peer support provider integration in teams, this study will discuss and identify challenges and opportunities faced by peer support providers in formal models of health care organizations. In particular, this section will expand on the definition and construction of peer support providers' role on the team, the boundaries with clients, interactions with external groups, implications of peer support provider role and services to clients, team, as well as themselves, and certification. The discussion section concludes with a summary comparison of APS and PS experience with role construction.

5.1. Defining and Constructing Peer Support Providers' Role on the Team

In this section, I discuss the two main topics to consider in role construction: peer support providers' relationships with team members, and dual roles of peer support providers.

5.1.1. Relationships with team members.

The most pertinent factor influencing the construction and definition of the peer support provider role was identified to be the team's perspective with regards to this role. Although the formal description of a position is an element of the role definition, the environment in which a role is carried has a major influence on shaping the role. There are two components to consider with respect to the facilitation of role acceptance of the peer support provider on the team: 1) The organizations' value and support of the peer support role, and 2) Stigma and negative attitudes from team members.

5.1.1.1. *Organizations' values and support of peer support role.*

Integrating a new role into an existing team requires effort on the part of the individual taking on the new role, as well as the established team. This process often requires several steps in order to facilitate the acceptance and empowerment of the role. In the literature, this facilitation came for the peer support providers when their teams better understood their role (e.g. tasks and responsibilities), the providers established relationships with their team and clients, and when the providers managed to adjust to their new work environment (Moll et al., 2009; Gillard et al., 2013). Studies have demonstrated that organizational support and leadership have an important influence on how well the team understands the value of the peer role (Carlson et al., 2001; Davidson et al., 2012; Moran et al., 2013; Wolf et al., 2010). The manner in which the peer support role is introduced to the team members can influence the initial responses of the existing team. In a review by Davidson et al. (2012), the researchers suggested that the introduction of the peer support provider role required the education, training and engaging of the existing team and staff in order for them to better appreciate the benefits to the various stakeholders. As a component of organizational support, time is also an important factor that influences role acceptance as the team and peer support providers familiarize themselves with the new role. Moll et al.

(2009) suggested that a peer support provider requires time and flexibility to explore the role. The education of the team members prior to the introduction of the peer support provider role helps foster an understanding that time will be required to settle in the role. Team members will be more accepting as peer support providers construct their role, providing room for flexibility (Moran et al., 2013). Chinman et al. (2008) added that over time, role acceptance from the team is likely to occur as the provider evolves and settles into their role.

In my study, organizational support, team education, and time were obvious issues in the participant responses. Most participants explained that their team members had been informed on varying levels of the role prior to their hiring. In most cases, participants emphasized that it took time for their role to be accepted on the team as an equal member. In comparison to PSs, most APSs commented on facing fewer difficulties in their role acceptance. This difference may be attributed to The ACT Program Standards, which mandates ACTT to have peer support providers on the team as equal members sharing a generalist role (MOHLTC, 2005). This mandate may have provided a formal justification for the existence of this role; however, it took time for the expertise of the APSs to be truly appreciated by the team. Both APSs and PSs mentioned that showing their expertise in the field of peer support allowed for a greater acceptance of their role. This clearly reflects studies by Moll et al. (2009) and Chinman et al. (2008) in discovering that team members became familiar with peer support over time, especially after they recognized the benefits and valuable input from peer support providers.

5.1.1.2. Stigma and negative attitudes from team members.

Another factor influencing role construction involves the disclosure of the provider's lived experience. The literature indicates that such disclosure can have positive and negative implications for the peer support provider. The disclosure of lived experience allows providers to establish rapport with clients and team members (Jacobson et al., 2012). However, it can also expose these providers to negative perceptions and acts of discrimination by team members and staff (Davidson et al., 2012; Gates and Akabas, 2007; Lammers et al., 2003; Moran et al., 2013). In fact, Gillard et al. (2013) and Gates and

Akabas (2007) identified that a lack of role acceptance was attributed to the persistence of stigma from team members and staff. These studies provided examples of the inability of the staff to distinguish mental health issues from work-related issues (Gillard et al., 2013). This notion was best illustrated when peer support providers became ill during the course of their service delivery (Davidson et al., 2012; Gillard et al., 2013; Gates & Akabas, 2007). Such negative perceptions may be expressed in the form of either direct or indirect forms of stigmatizing remarks (Moran et al., 2013). These types of behavior and their impact on role acceptance were evident in my study, however, the stigma often came from staff members and not team members as seen in the literature. Such staff members were usually identified as being part of the same organization, but not on the same team as the peer support providers. Staff members included varying levels of health care providers or administrative workers in the organization. In one instance, a PS participant discussed a situation where they felt that a human resources staff member was using subtle stigma in their conversation by referring to peer support providers as volunteers.

It is possible that such negative perceptions of peer support providers are due to the lack of contact between the providers and other staff members. In fact, the findings show that in teams where providers had greater interactions with other staff, as was the case for ACTT compared to non-ACTT, there was a greater level of understanding and appreciation between the team members. As such, the level of interaction may be a contributing factor to the understanding of the role and the attitudes held by team and staff members. This is because participants challenged staff perceptions by exerting more effort in their role, educating other team members, and confronting any stigmatizing remarks directly. In addressing such discrimination, participants felt that they were not only initiating change for themselves in the organization but also empowering their clients. These steps will not only facilitate role acceptance from team members, but also raise awareness of staff members of the capabilities of people with psychiatric disabilities (Chinman et al., 2008).

5.1.2. Dual roles.

Peer support providers are unique in that they take on a dual role as a health care professional as well as a client, and they may encounter difficulties negotiating between the

two roles. In taking on the peer support role, the provider is required to bring elements from their own experience as a client to their new role as a provider. This may cause confusion between the two roles. Carlson et al. (2001) talk about the balance of these two roles. In defining their roles, peer support providers may take time to adjust their roles on the team, and some may feel in the process that they are neither fully clients nor fully staff members (Gillard et al., 2013; Moll et al., 2009).

One potential difficulty associated with the dual role occurs when team members view the peer support provider as a client. Peer support providers may encounter problems with blurred boundaries when interacting with team members if they disclose information about their personal mental health (Moll et al., 2009). In fact, one study found that peer support providers thought their team members emphasized the client component of their role, whereas other team members weren't even able to distinguish between the two aspects of their role (e.g. client and provider role) (Gates & Akabas, 2007). One example in particular described a team member bringing up the peer support providers' medication compliance when the provider had been discussing a difficulty about work (Gates & Akabas, 2007). This duality was not visible in my findings, however, the second type of client-provider duality was discussed as a source of role confusion.

Another difficulty occurs when peer support providers feel their environment or discussions with clients serve as a reminder of their mental health experience. This was evident in this study's data. For example, an APS participant described encountering emotional triggers when first taking on the role and working in a hospital setting similar to the one in which they received mental health services. Such environment reminded the peer support provider about their own client experience of stigma and of hierarchical relationships with health care professionals. Another participant mentioned taking the necessary precautions to avoid feeling triggered by their clients: "There were some people that their circumstances and what they were going through was somewhat triggering for me. I had to actually take a step back from that and not engage with them". In both of these circumstances, participants mentioned overcoming this difficulty after feeling more confident in their services or by understanding their triggers and knowing when to seek help.

Many participants discussed reaching out to their team members for support if they felt unwell. One participant commented on having an understanding with team members about immediately taking time off if finding he/she felt overwhelmed with the amount of work. This type of action plan was more evident among ACTT participants than non-ACTT participants. This may be due to the amount of hours and type of work done in the two different models. The majority of the APS participants worked full-time and shared similar responsibilities to other providers, whereas PS participants focused primarily on their peer specialty. APS participants may have a plan and support in place with team members if their health is declining due to the intensive needs of ACTT.

Another type of duality discussed primarily by APS participants, was their dual role as a peer support provider and health care provider on ACTT. APS participants felt that in some cases, other non-ACTT peer support providers labeled their services on ACTT as ‘coercive’ and thus, not ‘true’ forms of peer support. APSs reported that they tried to remain within the peer support boundaries, staying close to the peer support ideologies while implementing a form of peer support within ACTT context. This type of behavior was noted in some studies as a role conflict, where the peer support providers’ status as a critic of the health care system conflicted with their status as a health care provider (Zipple, Drouin, Armstrong, Brooks, Flynn, & Buckley, 1997, p.413; Carlson et al., 2001).

Interestingly, in addition to the client-provider boundary that is discussed in the literature, my findings showed a different type of dual role. This duality was identified as occupying a peer support provider role and a health care professional role. This was mentioned by peer support providers who had previous education or work experience as a health care professional (e.g. Registered Practical Nurse, Social Worker, etc.). Only APS participants reported this dual role, finding it helpful to have a clinical background to work with team members on ACTT. As mentioned earlier, this type of duality involved using elements of the participants’ past clinical work and incorporating them into their current peer support provider role on the team. APSs with the professional background also noted experiencing an easier transition to their generalist role and understanding of clinical documentation. This dual role can act as an enabler in facilitating role construction and

integration into ACTT teams. However, the duality of the role also brought on difficulties when facing guidelines presented by their professional College. Most of the participants experiencing this duality commented on how their College (e.g. College of Nurses) required nurses not to talk about their personal life, which was in conflict with their role as a peer support provider. Thus, although some peer support providers saw this duality to be a "grey area", for the most part they believed it to be an advantage due to their educational background as well as the use of the alternative title when addressing groups that were less accepting of the peer support provider role. This finding has not been reported in previous literature.

5.2. Boundaries with Clients

The findings illustrated the challenges of developing disclosure boundaries with clients. The existing literature on peer support providers' boundary development with clients was discussed largely as a friend versus client dilemma. The literature proposes that the 'friend versus client' dilemma may affect confidentiality and information sharing; a client may give information as a friend and not necessarily as a client, which may potentially lead to problems regarding what information would be relayed to team members (Mowbray, Moxley, & Collins, 1998; Gates & Akabas, 2007; Moran et al., 2013). In the findings, only some participants noted the difficulty of maintaining an appropriate peer relationship when the clients began to take on a 'friend' oriented role. This type of 'friend' role became evident when clients wanted to meet with participants outside of their service relationship for social activities. As reported in the findings section, in one case, a PS participant was invited by a client to attend a family barbeque where the peer support provider would be introduced as a friend. Upon explaining to the client that there are boundaries to be observed, the PS noticed the client pull back.

This type of situation with the client led to the peer support provider distancing themselves from the client and potentially disrupting the rapport. However, if the peer support provider progressively pushed this 'friendship' boundary, it would eventually become difficult for the provider to separate their relationship as client and friend when providing their services. PS participants often experienced this more than APSs. This may be

attributable to the ACTT model where there is a clear provider-service user boundary, whereas in non-ACTT, the boundary with clients may be more flexible and developed by both the client and peer support provider.

In addition to the friend versus client dilemma presented above, there are other elements of disclosure that have not been explored in the literature. For example, what type of information the peer support provider would disclose to clients was discussed as an important factor when developing relationships with clients. Disclosing detailed information about their recovery story (e.g. illness diagnosis, medication) may lead to unrealistic expectations of recovery from clients. This is because clients may not appreciate that each experience of illness is different and the end results may vary from person to person. In some cases, peer support providers may also face the pressure of being a role model to clients (Moll et al., 2009). This challenge was reported in my findings, as participants mentioned that they needed to be aware of how they portrayed themselves to clients so that they didn't foster unrealistic expectations. There were differences between APS and PS participants in how and when they disclosed information about their lived experience. For most PS participants, they introduced their role to the client right at the beginning to allow the PS to draw parallel about similarities in lived experience. Whereas, APS participants often did not disclose their status of lived experience unless they felt it was necessary. APS participants discussed that over time, and with practice, they were able to develop skills that helped determine when to disclose lived experiences to clients. These differences in disclosure may be attributed to how the ACTT and non-ACTT models introduce the peer support providers. While peer support providers on ACTT were introduced as mental health counsellors to clients, they only disclosed their status of lived experience when they thought the client was interested in recovery. PSs, on the other hand, were often referred to clients by team members for peer services. However, the similarity between the APS and PS participants was that they both commented on only disclosing details about their lived experience when it helped the client.

Another element related to the topic of disclosure of lived experience, was the possibility of receiving a negative reaction from clients when disclosing the peer lived status

(Moran et al., 2013). A few APSs explained that some clients responded negatively to their disclosure of lived experience. This type of reaction may be associated with the type of clients who receive the peer service. While ACTT clients require intensive mental health services while being at a lower level of recovery, non-ACTT clients are usually at higher levels of recovery, and vary in terms of the level of services needed. For example, ACTT clients may not be receptive to peer services or understand the value of lived experience until later in their recovery, whereas non-ACTT clients may better appreciate benefits of the services as the findings indicated. Overall, boundary development and maintenance was an important area with respect to providing peer support services to clients. Most participants in the study mentioned that the disclosure of lived experience required time and practice, echoing the literature on the necessity for training opportunities for lived experience disclosure (Davidson et al., 2012; Moran et al., 2013).

5.3. Interactions with External Groups

As part of their role, peer support providers often have to interact with individuals outside their organization. The findings revealed important information regarding the types of external groups with whom peer support providers interacted. Most APS and PS participants mentioned that they had little or no difficulties when interacting with non-peer external groups (e.g. lawyers, community resource centres, hospitals). While PS participants interacted less with hospital and community services, APS participants were often in communication with such services. There were only a few instances in which APS participants felt that they were not acknowledged as an equal member of the team by external non-peer groups. This type of difficulty was not observed among PS participants. This may be due to the fact that the PS participants had less contact with the external groups.

The second type of external group that were in close contact to peer support providers were peer-run organizations and external peer support providers. Most participants had positive interactions with peer external groups as they offered a form of support and resources (e.g. training). Only in some cases did APSs feel that their services on ACTT were perceived negatively by peer external groups. As mentioned earlier, APSs are not only a part

of the peer movement, they are also health care providers who may be judged negatively by other peer groups.

5.4. Implications of Peer Support Provider Role to Clients, Team, and Themselves

Several client benefits associated with the peer support provider role have been reported in the literature, including improved quality of life (Bean et al., 2013), reduced stigma (Davidson et al., 2006), and empowerment of clients (Repper & Carter, 2011). Studies have also shown that the peer support provider role has allowed other health care providers to better understand the needs of their clients (Lawn et al., 2008; Davidson et al., 2012) and recovery-oriented care (Jacobson et al., 2012). The findings from my study also demonstrate the perceived value of the peer support role as an addition to the mental health care team. The participants were able to point out the positive and negative elements of their services with respect to their clients, teams as well as themselves. For the most part, both APS and PS participants reported perceiving similar benefits of their services. When it came to negatives of their services, APS participants mentioned that if they felt sick, they would be unable to continue providing peer support to their clients. This negative was also associated with the stressful work environment of ACTT, with APS participants commenting on the loss or injury of clients and noting that workload stress may require immediate time-off. The intensity of the ACTT model (e.g. 24 hours, 7 days a week) and severity of client illnesses may be factors contributing to work stress. These negatives were not discussed by PS participants, who may experience less of these implications in their role on non-ACTT.

5.5. Certification

Recalling the literature on certification, we can see that the implementation of certification and standardization of peer support has been widespread in the United States. Studies have generally found responses from certified peer support providers to be positive (Salzer et al., 2013; Ratzlaff et al., 2006). Campbell and Leaver (2003) argued that certification fosters the growth of a qualified and ethical workforce and that health care organizations will recognize the peer support provider role as a legitimate profession through certification and training. The findings from my study brought up similar interest in the national peer support certification program, the Peer Support Accreditation and Certification

(Canada). Most APSs and PSs were interested in becoming certified to help provide credibility to their role within the organization. For some participants, the certification would provide structure to their role. In these cases, participants often lacked access to resources and found that a certification program would provide ample sources of information on peer support and its implementation within traditional health care settings. However, a few participants wanted more information and research on the certification process and outcomes before supporting the implementation in Canada. Overall, participants displayed significant interest in the process of certification and accreditation.

5.6. Comparison of APS and PS participants

The findings of this study point to similarities and differences when comparing APS and PS participants in their integration on the team. Table 8, below, provides a summary of these comparisons.

Table 8: Summary Comparison of APS and PS participants		
	APS	PS
Titles	Similar across ACTT (e.g. Peer specialist)	Variations across models
Responsibilities	- Full-time (common) - Similar generalist role	- Part-time (common) - May take on administration role
	Similar responsibilities of the peer support role – e.g. WRAP, one-on-one with clients	
Training	- Some participants have clinical experience from previous work experience/education - Variation in amount of peer support training provided by organization (e.g. shadow others)	- Most participants have prior peer support provider experience - Most received peer support training from organization
	Similar training courses and programs (e.g. WRAP, Pathways to recovery)	
Frequency of interaction with team members	- High level of contact with team members due to generalist role - Participate in team meetings as an equal member (e.g. Kardex)	- Varying levels of contact with team members - Variations in level of participation on team - See some team members more often than others
Role acceptance	- Generalist role accepted earlier on - Participants take on additional tasks to remove token identity	- Need to maintain positive relations with team members for client referrals
	Peer support provider role takes time to be accepted as an equal role on team. Educate team members about benefit over time.	
Remuneration	Variations across ACTT (e.g. high to low)	Low remuneration
Dual roles	- Peer support provider versus health care professional - Peer as equal versus peer as provider	
	Client versus provider	
Disclosure	Disclose title and lived experience when necessary to clients.	Title often disclosed in introduction. Peer support provider discloses status of lived experience in

		initial contacts to develop a relationship. - May face friend versus client dilemma
	Consider carefully what and when to disclose information about self. Share information about self with team members when relevant in advocating for clients.	
Certification	Mixed responses about certification, but mostly positive. Need more research and information for peer support providers to support the certification process.	

Overall, the role integration was similar for both APS and PS participants. The differences in their integration could be generally attributed to the context of ACT and non-ACT models. The regulation of ACTT models by The Ontario Program Standards (MOHLTC, 2005) provides clearer requirements about the peer support provider role in conjunction with the generalist role (e.g. position title, hours of employment, generalist role responsibilities). The generalist role also contributed to higher frequency of contact with team members to discuss clients' status (e.g. Kardex). This differed for PS participants who had varying levels of contact with team members and were not required, in some cases, to participate in meetings.

Regardless of the differences, participants had similarities in the factors influencing their role integration on the team. However, these factors varied in their weight depending on the models. For example, both APS and PS participants mentioned taking time to integrate as an equal member of the team. Yet, PS participants felt more hesitant in voicing their opinions on the team in fear of alienating team members with client referrals. Another factor shared by both APS and PS participants involved the access to similar types of peer support and recovery-oriented training.

Dual roles was another factor influencing integration among both groups, with 'client versus provider' shared as a duality. While this duality was seen among both APS and PS participants, APSs often had an action plan if they felt unwell. In addition, some APSs faced another duality – 'peer support provider versus health care professional', brought on by difficulties in following their professional College requirements. For the most part, APSs encountering this duality perceived it as an advantage in facilitating integration of their generalist role on the team. Another duality was 'peer as equal versus peer as provider'; this duality was only brought up by APSs who felt that non-ACTT peer support providers

considered their services on ACTT as ‘coercive’. PS participants did not mention experiencing this type of duality; this difference may be attributed to PSs only experiencing the peer specialty role and not the generalist role experienced by APSs.

Disclosure of lived experience was another shared factor influencing integration. Both APS and PS participants commented on carefully considering what and when to disclose information about themselves; however, differences in their disclosure often came in the introduction of their role to clients. APS participants often waited to disclose their peer title and role until they felt the client was ready to discuss their recovery. PS participants had a different approach, in which their role was introduced to the clients initially. This approach was due to the referral scenario commonly mentioned in non-ACTT models, where clients were informed of their referral by their health care providers to receive peer specialty services. This scenario was different in ACTT, where APSs were introduced as mental health counsellors, and only disclosed lived experience when they felt the client was ready to accept peer services. This difference can also be attributed to the type of clients receiving the services at ACTT (e.g. intensive services) and non-ACTT (e.g. variations in intensity of services) models.

In terms of certification, the views were similar: both groups perceived it positively, but commented on the need for more research and information to support the implementation of the certification process across Canada.

6. Conclusion

In this section, I summarize the contributions of this study and provide recommendations for health care organizations and peer support providers. Additionally, I address the limitations and opportunities for future research.

6.1. Contributions

Overall, this study contributed an in-depth understanding of the factors influencing role integration in ACTT and non-ACTT models. The study showed that multiple factors come into play when integrating a new role into an inter-professional mental health team. The findings point to the underlying importance of the peer support provider role complexities and benefits when integrating into formal health care organizations.

This study reported on the findings of the elements involved in defining and constructing peer support providers' roles in inter-professional mental health teams. More specifically, I contributed information on the context of participants' experiences in integrating on the team. In doing so, I contributed a background in the evolution of their peer support provider role on ACTT and non-ACTT models. While reporting their experiences, I was able to gather information on peer support providers' interactions with team members, clients, and external groups. In providing this context of their experiences in interacting with stakeholders, it facilitated an understanding of how and what factors influence peer support providers' integration.

Additionally, as part of investigating the role of peer support providers on teams, I made efforts to understand participants' views of the implications of their services. Based on the participants' responses, I was able to provide an overview of their perceived impact on clients, the team, and themselves. In doing so, the findings contributed to peer support providers' perception of both positives and negatives to their services and their effect on key stakeholders.

Further, a comparison was made of APS and PS participants to identify factors influencing their integration into their respective models, ACTT and non-ACTT. The comparison showed similarities and differences in obstacles and enablers. For the most part,

participants from both models shared similarities in their views of their role integration on the team. The distinctive features identified from the two participant groups stemmed mainly from the contexts of the models, with one model more regulated than the other.

Furthermore, I was also able to gather a preliminary understanding on peer support providers' thoughts on the implications of introducing national peer support certification to Canada.

6.2. Implications for Practice

There are several implications for practice based on a) participants' recommendations during the interviews, b) the findings of the study, and c) the literature. I provide recommendations for health care organizations and peer support providers regarding integration of this role into mental health teams.

6.2.1. Recommendations to health care organizations.

Recommendation 1: Define the peer support provider role

An important element is defining the role prior to hiring the peer support provider. This role may not need to be narrowly defined but should have enough substance to help the peer support provider start off in the right direction. Some participants mentioned that it is necessary for the team members to identify what types of tasks or activities the team would like the peer support provider to engage in.

Recommendation 2 - Introduce peer support to team and staff

It is important to prepare and educate current staff regarding peer support, and to emphasize the value of the role. Teams looking to introduce the peer support role may find it beneficial to approach other teams that have experience with the role. Seeking information and sharing with other teams may assist in developing a better understanding of how the role can be constructed on a team. Education concerning peer support is also suggested as a way to challenge stigma from members of the organization.

Recommendation 3: Set-up meet and greet, and interaction opportunities

Inviting peer support providers to meet with team and staff members can be a valuable experience. As one participant mentioned, spending an afternoon with the peer support provider could potentially decrease negative attitudes towards the role by other team and staff members.

Recommendation 4: Offer training

It is also important to provide peer support training. In providing this opportunity, peer support providers are able to learn essential tools used to facilitate programs and workshops for clients. Additionally, in offering financial means to seek peer support training, peer support providers are able to attend conferences and events where they are able to develop relationships with peer support providers in the community.

6.2.2. Recommendations to peer support providers.

For individuals about to take on the role of peer support providers on mental health team, it is important to be keenly aware of one's own health status and recovery. Developing and maintaining coping mechanisms such as meditation, support from family, friends, and peers, were suggested by many participants as helpful. In addition to maintaining health status, it is recommended that peer support providers integrate slowly and take the time to learn about the role. In the words of one participant:

“I really think you have to be flexible and again knowing you're in a position where you're going to be challenged a lot, and you're going to have to challenge. Understand who you are, why you're there, and understand your role. If you lose sight of what your role is, you'll fall apart and you'll be sucked into the system or go into long-term disability leave... Don't worry about winning every battle... look at the end, the long-term goal....”

Integrating peer support providers is a collaborative process among team members, staff, the peer support provider, and the overall organization. It is necessary to slowly integrate into the team and provide room to be flexible in defining the role. The process of

integration involves continuous, on-going evolution which, over time, leads to more significant changes.

6.3. Limitations and Transferability

The study has several limitations, the first of which refers to participant recruitment. In recruiting participants for this study, I focused on Ontario and found it easier to locate peer support providers in ACTT than in non-ACTT. This limitation was reflected in the participant population, with eight participants recruited for APS and only four for PS, despite numerous attempts to locate non-ACTT participants. Further research may attempt to go beyond a single province allowing inclusion of a bigger number of participants, and in different geographic locations. The second limitation concerned the variability of non-ACTT models. In the study, I focused on comparing peer support providers from ACTT and non-ACTT models. Participants' experiences were generally similar in ACTT likely due to the regulation by The Program Standards. However, there was greater variability in the experiences of participants from non-ACTT models. The differences in non-ACTT models was not investigated as part of the study, but context information was provided on PS participants' teams and programs. Third, this study was cross-sectional. Using a longitudinal approach to research on role integration and cultural change on the team would provide deeper insight.

An important question is whether the findings from the study are transferable. Are the findings applicable to other ACT and non-ACT peer support providers and teams? The experiences discussed by participants are their own opinions and are relevant in the context of their teams; they are not generalizable at large. Although, this may be seen as a limitation of the study, the strength of qualitative research lies not in allowing generalization, but in providing insight into participants' meanings (Creswell, 2013). I have provided extensive information and quotes on the participants' experience and its context that I hope allows the reader to determine whether the findings can be transferred to other contexts. This study provided information on the context of participants' experiences in integrating on mental health teams.

Finally, my research findings contributed knowledge on the definition and construction of peer support providers' roles within teams. As the value of peer support provider integration in mental health teams is recognized, and as discussion of peer support certification progresses, I hope that my study provides insight and a good base for future studies.

7. References

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8. Appendix

8.1. Framework of Different Peer Support Employment Models

Informal/Formal Status	Type of Peer Support Structure	Description	Examples
Informal	Friendship (MHCC, 2013)	Individuals developing reciprocal relationships in an environment with minimal or no regulation for peer support (MHCC, 2013, p.17). This is a naturally occur relationship between two voluntary individuals who may be participants of psychosocial of social focused activities within the community (MHCC, 2013, p.17).	Two individuals attend a workshop on anger management; they develop a reciprocal relationship regarding their personal experiences with mental illness.
	Clubhouse/ walk-in centre (MHCC, 2013)		
	Peer Education Groups (Woodhouse & Vincent, 2006)	A group of individuals or an individual will provide information on a topic to another group of individuals with similar characteristics (Woodhouse & Vincent, 2006). Self-help groups may also consist of a peer or clinician facilitating a program as sponsored by a mental health or community agency (Solomon, 2004; O'Hagan et al., 2010, p.18).	A youth group who may have experienced depression will go to other schools and speak with the youth population about the issue. An online peer support forum may also be considered; for example, a mixed method study by Horgan, McCarthy & Sweeney looked at the effectiveness of an on-line peer support forum of university students (2013). An example of a self-help group may include "Organization for bipolar affective disorders" and "Manitoba Schizophrenia Society" (O'Hagan et al., 2010, p.18).
	Self-help, Mutual Peer Support Group (MHCC, 2013; O'Hagan et al., 2010)		
Formal	Independent Peer Run Initiatives (O'Hagan et al., 2010, p.50)	Peer run organizations funded independently for projects by the government. These projects may include drop-in programs or services used by members of the community. They are 'freestanding legal entities' (O'Hagan et al., 2010, p.20). They provide drop-in centres for consumers of mental health services to obtain information about health services and workshops (Woodhouse & Vincent, 2006). This group also performs "systemic/individual advocacy" to lobby for issues pertinent to the consumer population (MHCC, 2013, p.17). In the United States, services provided by these organizations may be considered an alternative to mainstream clinical institution services (Woodhouse & Vincent, 2006).	An example of independent peer run initiatives may consist of the Psychiatric Survivors of Ottawa and Mental Health Client Action Network (Woodhouse & Vincent, 2006).
	Peer partnerships with mainstream agencies (Solomon, 2004; O'Hagan et al., 2010)	Peer partnerships with mainstream agencies include peer support providers as the primary organizer of the group (Solomon, 2004). Although the peer support provider will hold a large control over the group, the mainstream agency will share some responsibilities (e.g. planning, operating, administrating and evaluating) including providing funding for the program (O'Hagan et al., 2010, p.20).	An example of peer partnerships may include peer support programs offered within the health care institution that is open to all patients(e.g. Wellness Recovery Action Plan (WRAP)) (O'Hagan et al., 2010, p.20; Gilliard et al., 2013).
	Mainstream Agencies that employ individuals to provide peer support (O'Hagan et al., 2010) - Include both ACTT & Non-ACTT	Community peer support providers are hired by mainstream agencies (e.g. hospitals) or community health centres to focus on delivering peer support to outpatients or consumers within the community (MHCC, 2013). A similar team model is applicable within the health care organization (e.g. mainstream agency) using inter- and trans-disciplinary team arrangements to treat in-patients and outpatients of the hospital.	Peer support providers in Assertive Community Treatment (ACT) Teams, Case Management teams or as counsellors within community health centres (MHCC, 2013; Chinman, Oberman, Hanusa, Cohen, Salyers, Twamley & Young, 2013). This may include peer support providers working on inpatient/outpatient programs, rehabilitation centres, crises response teams, psychiatric emergency rooms, etc. (MHCC, 2013).

8.2. Interview Protocol

Interview Protocol

Note: The structure of the interview will be a mixed approach of an interview guide and a standardized open-ended interview. The format used will be a semi-structured interview to engage the participant to explore certain subjects more in-depth. The outline of this interview is following the concept introduced by Patton (2002, p. 422-423) in Qualitative Interviewing.

This interview will be conducted with integrated peer support providers in inter-professional mental health care teams. The participant has received a consent form to sign, agreeing to consent to the interview. The interview will be recorded for data analysis.

Memo to participant:

Thank you for taking the time to participate in the interview. I have some questions for you about your background as a peer support provider as well as some questions about your team. You have signed the consent form for this interview to be recorded. Your interview data will be kept confidential and any identifiable information will be removed. I would like to let you know that there are no right or wrong answers and that I am looking for your unique perspective as a peer support provider in order to understand the role.

- 1) What is your current title and role?
- 2) Can you tell me briefly about your career history?
 - a. What other roles have you occupied in your career?
 - b. How did you come to the decision to work as a peer support provider?
 - c. Overall, how long have you been practicing as a peer support provider?
 - d. Would you mind telling me about your experience with mental illness?
- 3) How long have you been associated with the team you are currently a member of?
 - a. How long have you been practicing as a peer support provider on this team?
 - b. What training, if any, have you received in mental health service provision?
 - Have you received any training for peer support service delivery?
 - Would I be able to access any of these documents?
 - c. Do you receive remuneration for your work as a peer support provider?
 - If so, how does it compare to the remuneration of other members of the team?
- 4) Can you describe your role on the team?
 - a. What are your responsibilities?
 - b. What do you contribute to the team in terms of your roles and skill sets?
 - c. What other roles have you occupied while on the team?

- d. What roles do the members on your team occupy? (Nurses, Psychiatrist, manager?)
- 5) You mentioned that your role on the team involves Has your role evolved since you joined this team? If so, how?
- 6) What is it that accounts for the change in your role? How can you explain the change?
- Legislations/Mandates?
- 7) How is your current role similar to or different from the roles of other mental health care counsellors on the team?
- 8) From your perspective, what do you think of your team members' understandings of your role as a peer support provider?
- a) Responsibilities? Boundaries?
- 9) I would like to ask you about any difficulties you might experience as you perform your role as a peer support provider.
- a) Let's start with difficulties associated with your role within the team.
 - b) Role boundaries?
 - c) Interactions with team members.
- 10) What about difficulties you experience in dealing with groups other than the team.
- a) Let us talk about clients. What difficulties do you experience as a peer support provider in dealing with clients?
 - Do you disclose your role to the clients?
 - b) What other groups do you interact with in the course of your work?
 - c) Do you experience difficulties interacting with these groups?
 - If so, what are the difficulties?
- 11) Stigma associated with mental illness has been noted in Canadian literature; including reports such as 'Out of the shadows at last', which have provided insight about individuals who are ill or are recovering from mental illnesses. How, if at any point, has stigma associated with mental illness affected you?
- A) How you deliver the service?
 - B) The interaction with other team members?
 - C) How you interact with health care professionals not part of your team?
 - D) Clients?
- 12) How do you deal with these difficulties (effects of stigma)?

13) We have talked about the difficulties. Let's now talk about the factors that have enabled you to take this role as a peer support provider in an inter-professional team?

14) Being a peer support provider, you're integrated within a group of providers and you provide services to clients. Based on your experience, how does your work on the team benefit the client?

- a) How does it benefit the team?
- b) Are there any negatives to the clients?
- c) Are there any negatives to the team?

15) What benefits do you take from working as a peer support provider on this team?

- a) Are there any negatives?
- b) How does participation on this team impact your own mental health?

16) Have you heard about the national certification for peer support providers from Peer Support Accreditation and Certification Canada (PSACC)?

- a) If not, provide participant brief explanation and go to question 10b.
- b) If yes, how will this certification process impact your service delivery?
 - Role on the team?
 - Clients' perception?
 - Mental health organizations?
- c) Would you be interested in obtaining this certification?
 - If yes, how would you feel about peer support providers who would not?

17) In the next few years, where do you see the direction of peer specialists going within mental health care?

18) My last question is about recommendations you might have.

- a) What recommendations would you have for team leaders and team members regarding integrating peer specialists in the mental health team?
- b) What recommendation would you have to individuals about to assume the role of peer support provider on a team?

19) What have I not asked you but should have asked you to understand the peer support provider role or experience?

8.3. Contact Summary Form

Contact Summary Form

Contact Type:

Site:

Contact Date:

Today's Date:

Written by:

1: What were the main issues or themes that struck you in this contact?

2. Summarize the information you got (or failed to get) on each of the target questions you had for this contact:

Question	Information

3. Anything else that struck you as salient, interesting, illuminating or important in this contact?

4. What new (or remaining) target questions do you have in considering the next contact with this site?

8.4. Interview Consent Form



Interview Consent form

Title of the study:

The role of peer support workers in inter-professional mental health care teams

Sarah Asad

Telfer School of Management, University of Ottawa

Samia Chreim (Ph.D)

Telfer School of Management, University of Ottawa

Invitation to participate: I am invited to participate in the abovementioned research study conducted by Sarah Asad, MSc. candidate at the Telfer School of Management, University of Ottawa, and supervised by Professor Samia Chreim, Telfer School of Management, University of Ottawa. This research study is being conducted independently from the organizations/agencies with which you are associated.

Purpose of the study: I understand that the purpose of the study is to improve understanding of the role of peer support providers in inter-professional mental health care teams. The study will explore the role construction of peer support providers, focusing on obstacles and enablers to their integration and service provision within inter-professional mental health care teams. The study will also look at peer support providers' view of the implications of serving on teams to the clients, the team, and the peer support providers themselves. Additionally views on implications of introducing peer support certifications will be obtained. The data retrieved from this research will be included in Sarah's eventual Master's thesis.

Participation: My participation will consist essentially of taking part in an individual interview lasting approximately 60 to 90 minutes at my office or at the university. This interview will consist of answering questions related to the integration of peer support workers in mental health teams. I am aware that I do not have to answer any questions that I do not want to answer. I agree to this session being recorded for data collection purposes only, and understand that this information will be kept private at all times.

Should it be my preference, I will be given the opportunity to review my comments after the interview is transcribed, make changes to the information provided during the interview, or to withdraw data from the study. If I would like to receive a copy of the interview transcript, I will provide a mailing address or an e-mail address. I realize that material sent via email has the risk of being intercepted by someone in the organization or by a hacker, thus risking confidentiality and that no further security measures will be taken.

Risks: I understand that since my participation in this study will entail that I volunteer information regarding my peers, it may cause me to feel hesitant about disclosing information. I have received assurance from the researcher that every effort will be made to minimize these risks by maintaining anonymity through disguising my name and the organization's name, and by disguising any identifying information.

Benefits: My participation in this study will provide an opportunity to contribute my perspective regarding the role and integration of peer support providers within inter-professional mental health care teams. My participation will contribute to an advancement of knowledge on the role of peer support workers within inter-professional mental health care teams.

Confidentiality: I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for the above project and that my name (and organization) will not be disclosed when presenting the results of the research.

Anonymity: While the published research may include some quotes of the transcript of the interview, in the event of any such quotes, all information concerning the identity of the participants or their organizations will be coded such that the identity of the participants will remain confidential.

Conservation of data: The data collected (digital recording of interview, interview transcript, and handwritten notes) 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 10 years and destroyed thereafter. Only the researcher and her thesis supervisor will have access to the interview data.

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 any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed.

Acceptance: I, _____, agree to participate in the above research study conducted by Sarah Asad of the Telfer School of Management at the University of Ottawa, under the supervision of Professor Samia Chreim. I understand that by accepting to participate I am in no way waiving my right to withdraw from the study.

If I have any questions about the study, I may contact the researcher or her thesis supervisor.

If I have any ethical concerns regarding my participation in this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa.

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: _____

Date: _____

Researcher's signature: _____

Date: _____