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# LITERATURE REVIEW

## Challenges Associated With the Implementation of Peer Staff Roles in Mainstream Mental Health and Addiction Agencies

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Prepared for Self Help by Jay Harrison & Julia Read

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Self Help is a service of Canadian Mental Health Association, Waterloo Wellington Dufferin. Self Help provides peer support-self help services for those who experience a mental health and/or addiction issue. At Self Help we believe that the unique combination of self help and peer support, as guided by our Recovery Values and Principles, provide the place and opportunity for people to explore their very personal journey of recovery. We believe that recovery from a mental health and/or addiction issue is possible. All our services are provided by people who experience a mental health and/or addiction issue for people who experience a mental health and/or addiction issue, making this service unique within the larger addiction and mental health system.

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## A Note on Language

The literature that describes and explains the experiences of peer staff working in mainstream mental health and addiction agencies is not uniform with respect to the terminology used. Therefore, we offer a few clarifications on how we have tried to use language consistently in our review of this literature.

**Mental distress.** The literature uses several terms to refer to the various distressing experiences that constitute the valuable “lived experience” for which peer staff are hired. We have used the term “mental distress” throughout this review except in cases where different terms were useful in better understanding the claims being made by the original authors.

**Peer staff / non-peer staff.** While any staff working in mental health and addiction services may have lived experience of mental distress, we distinguish here between staff who are explicitly invited to use their lived experience as part of their role (peer staff) and those who are not (non-peer staff and colleagues).

**Service user.** We have generally used the term “service user” to refer to people with lived experience of mental health and/or addiction issues who are on the receiving end of services, including the services provided by peer staff. We also use this term to distinguish between peers who access services and peer staff who provide services.

**Mainstream mental health and/or addiction agency.** “Mainstream” is used here to identify agencies that are **not** run by peers (e.g., consumer/survivor initiatives, consumer-run organizations, etc.).

## Background

Since 2010, Self Help’s Centre for Excellence in Peer Support has implemented and supported peer worker roles throughout the regional addiction and mental health system. Currently the Centre for Excellence provides training, supervision, and coaching to 12 peer workers working in a variety of settings including hospitals, community health centres, addiction services, and internal CMHA departments.

The Peer Support Research Project (PSRP) is the first peer-led community-based research project of the Centre for Excellence in Peer Support. In 2015 the Centre undertook an inclusive peer-driven process to develop a research question that would be used to initiate a peer-led research process. The project – led by a steering committee of peer staff from mental health and addiction agencies, a project coordinator from Self Help, and two external peer researchers hired as principal investigators – aimed to answer the following question:

*What is the experience of implementing peer staff roles in non-peer mental health and addiction organizations and what are the strategies and opportunities for supporting successful implementation of these roles?*

This literature review was one component of the PSRP. The purpose of the review was to inform the development of subsequent aspects of the project including the development of a reflective practice tool for organizations that employ peer staff (a copy of this report can be found at [self-help-alliance.ca](http://self-help-alliance.ca)).

## Methods

The literature review was guided by the following question: *What are the common role implementation issues faced by peer staff?*

Relevant academic and grey (non-academic) literature was reviewed that specifically addressed the implementation issues associated with peer positions. The scope of the review focused on paid peer staff and did not include articles with a focus on volunteer peer support providers. Additionally, the articles reviewed were focused on peer staff in mainstream settings and did not include articles with a focus on peer positions in peer-led organizations.

The implementation issues identified in the literature review were validated with the project steering committee comprised of peer staff from mainstream mental health and addiction agencies. The validation process helped us to deepen our understanding of the complexity of the issues that can arise when implementing peer staff roles. As an aide for exploring this complexity we developed a “journey map” which helped us to understand the system in which peer staff are employed by mainstream agencies and in which implementation issues arise. The journey map was adapted from an employment system map developed by the MaRS Solutions Lab (van den Steenhoven, Koh, Laban, & Geobey, 2014).

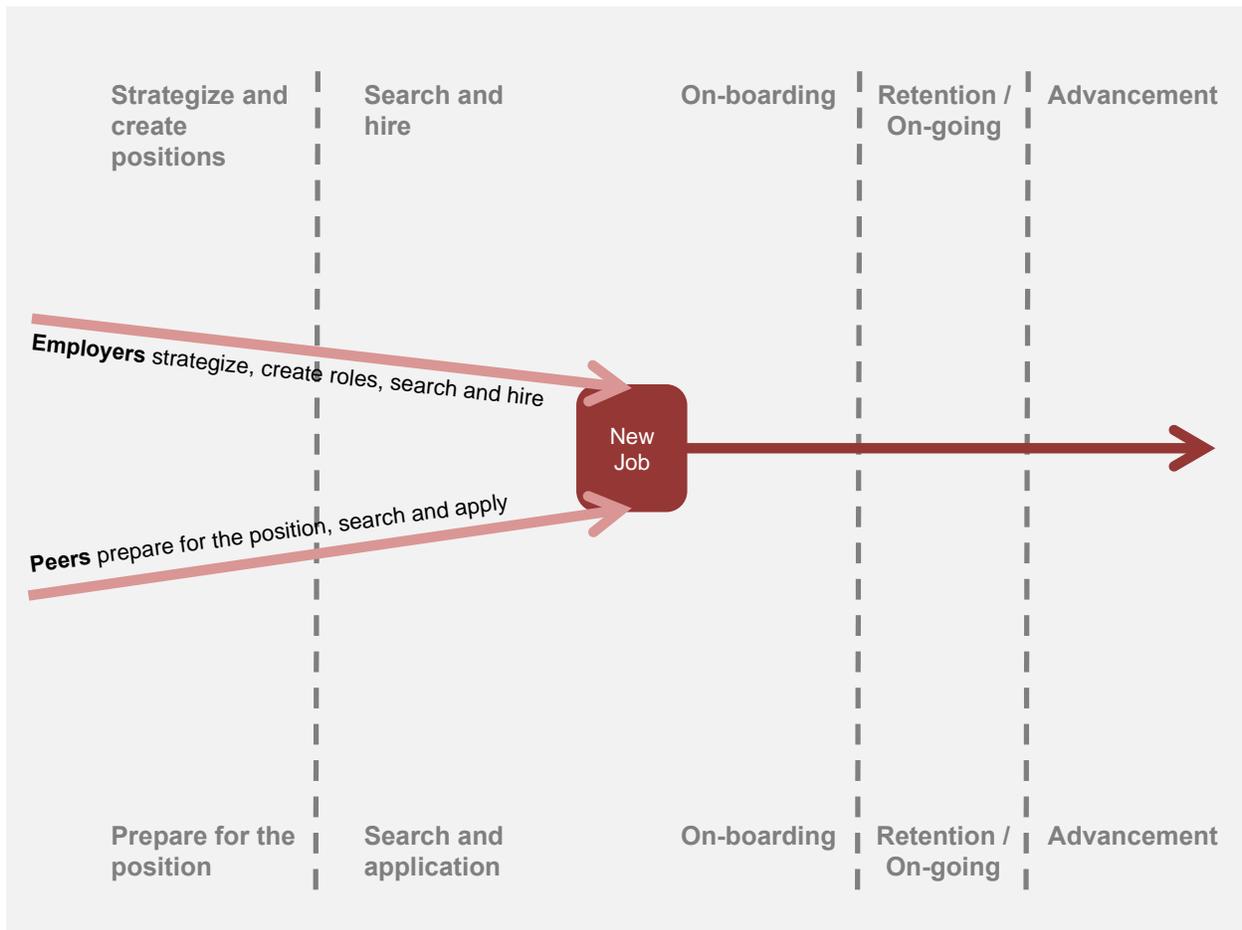
## Peer Staff Journey Map

The journey map is a simplified model of the system in which peer staff employment occurs. It is a heuristic tool for thinking about the journey of peer staff and employers that can be used to explore the nature of the challenges experienced and identify leverage points for effecting systemic change to improve practice.

As a simple representation of the peer staff journey, the journey map does not include some important dynamics including that the actual process is far less linear and far more cyclical than the map suggests, particularly in the post-hire phase. However, the map provides some immediately useful concepts for thinking about the implementation of peer roles:

- There is a pre-hire phase when peer staff positions are created that can have important effects on the post-hire phase of implementing peer staff roles.
- There are at least two meaningful periods to consider in the pre-hire phase and these may look different for employers and for peers. The pre-hire phase for employers may be characterized by strategizing and creating positions as well as search and hire to fill the position. For peers, the pre-hire phase may be characterized by preparing for the position as well as search and application.
- There are at least three meaningful periods to consider in the post-hire phase: on-boarding, retention / on-going, and advancement.

## PEER STAFF JOURNEY MAP



Adapted from a system map created by the MaRS Solutions Lab. van den Steenhoven, J., Koh, J., Laban, S., & Goebey, S. (2014). *New Solutions to Youth Employment Lab: First Report – Draft*. Toronto, ON: MaRS Solutions Lab.

## The Complexity of Implementation Issues That Peer Staff Experience in Their Roles

It is apparent from the research on peer staff roles in mainstream mental health and addiction agencies that the common

implementation issues that peer staff face are often the symptoms of deeper, systemic issues. In a complex system, such as a mainstream mental health and addiction agency, implementation issues might serve as signals of more systemic organizational issue that may need to be addressed. In this way, peer staff positions can be seen as a catalyst for revealing those deeper trends by injecting a “disruption” into the system.

Peer staff are inherently disruptive role innovations (Deegan, 2011). The very nature of peer roles and the common

implementation issues that accompany them raise a number of critical questions concerning the social, technical, legal and moral culture of the organizations that employ them. For example,

- “Are the ‘boundaries’ that peers negotiate in order to engage in a unique and effective practice compatible with the service model and legal and ethical framework of the organizations in which they are employed?”
- “Is the ‘sameness’ between peer staff and service users that is a hallmark of such positions still valuable when there is a power imbalance between peer staff and service users which may tend to be the case in mainstream mental health and addiction agencies?”
- “Is it possible for peer staff to model recovery in an organization that isn’t recovery-focused?”
- “What do the common implementation issues of peer staff tell us about the universal design of mentally healthy workplaces?”

To a certain degree the success of peer roles is dependent on an organizations ability to adapt to the disruption created by the introduction of peer staff. This may require both operational (i.e., hiring and accommodation policies) and strategic (i.e., organizational mission) shifts in how organizations operate. When organizations do not adapt to peer roles the disruption is born by the peer worker. This shifting of the burden is manifested as the common implementation issues identified in this review.

The nature of implementation issues is highly interrelated and contingent such that it may be difficult to isolate any single issue

for focused intervention. The interrelated nature of the issues suggests that it may be more appropriate to address them holistically than in isolation. The implication for potential recommended practices is to focus on those practices that target the underlying root causes of the implementation issues.

The nature of implementation issues for any given peer position will vary depending on the type of work (e.g., group vs. individual; outreach vs. case management; team vs. solo) and nature of the setting and context in which the work is performed (e.g., recovery-oriented; reason for creating peer position; number of peer staff employed in the setting; hospital vs. community-based).

Additionally, the nature of implementation issues vary across time. Within the field of mental health and addiction the nature of implementation issues is changing over time as the field and accepted practice shift and change. Past published research points to a trend in which peer roles were once dominated by demonstration projects run by researchers, and roles owned by peer-led organizations. However, the field has shifted and a greater amount of contemporary research is concerned with peer positions within mainstream mental health and addiction agencies. Implementation issues can also vary within a single organization over time as the organization gains experience with peer roles. This does not mean that implementation issues will necessarily improve in all organizations over time. Whether or not implementation issues improve will be, at least in part, a function of how well an organization adapts to what they learn from their experience with peer positions. Finally, the nature of implementation issues for any given peer staff will vary over time as they gain

experience with the role and interact with shifts in their environment.

## Accommodations

The duty to accommodate employees with mental health issues is part of the Ontario disabilities act and is regulated by provincial law (Ontario Human Rights Commission, 2015). Once an employee has requested accommodation, it is the responsibility of the employer to accommodate. The accommodation should happen in a timely manner that respects the employee's dignity and confidentiality (Ontario Human Rights Commission, 2015). Although provincial law regulates workplace accommodations, issues related to the implementation of healthy workplace policies and access to accommodations were identified in the literature as a challenge for some peer staff (TaylorNewberry Consulting, 2014). Furthermore, it may not always be easy for employers to distinguish between situations that require accommodations and those that arise as a result of challenges associated with the structure of the role and challenges with colleagues (Fisk, Rowe, Brooks, & Gildersleeve, 2000).

In a recent mixed methods study of peer staff in Ontario, TaylorNewberry Consulting (2014) identified some of the concerns that peers have expressed about accessing and utilizing accommodations. Peer staff noted that there is a certain amount of risk or perception of risk for people with mental distress in accessing accommodations because of the stigma associated with disclosing. This is particularly critical for peer staff as their capacity to fulfil their job duties could be called into question. For example, peer staff may have concerns about taking time off from work to attend to

their recovery, or they may be concerned that taking time off from work for other reasons may be perceived by others as being due to their mental distress. Peer staff may worry that using accommodations are a signal to their employers and colleagues that they are not competent to do their job. They may also worry that employers will perceive their use of accommodations as evidence that the peer support role is not viable. As most peer roles are part-time and do not include access to benefits, a leave of absence or reduced hours will lead to an inevitable loss of income. Peer staff also worry about how they will be received by their employer and colleagues when returning to work after taking time off (TaylorNewberry Consulting, 2014). Challenges related to accessing accommodations may be exacerbated when supports for personal wellbeing, including accommodations are not universal for all staff in the organization (Repper, Aldridge, Gilfoyle, Gillard, Perkins, & Rennison, 2013).

Even when provincial law mandates accommodations, it does not guarantee that employers understand the Disability Act and duty to accommodate. Peer staff may fear potential resentment from their employer and co-workers due to this lack of understanding and the impact it could have on their future in the organization including promotions and other work incentives (Fisk et al., 2000).

## Application Process

The process of applying for a peer staff role may present challenges for some candidates. The literature notes particular barriers that candidates for peer roles may experience, including, sporadic employment

history, instability in housing, and having a criminal record. Many people with lived experience may face challenges from having been out of employment for some time, which can lead to a lack of confidence or skills to apply for a job (Naughton, Collins, & Ryan, 2015). Further, they may not know how to talk about interruptions in their employment history or to explain why there are gaps of unemployment or underemployment with an employer (Naughton et al., 2015). Housing stability or precarious housing may be connected to a person's sporadic employment; for example, as a result of having spent time in an institution to manage symptoms (Repper, 2013). Another challenge in the application process is the requirement to complete a police record check (Repper, 2013). Providing proof of a "clean" record is a common procedure for most social service agencies and may prevent barriers to employment for some otherwise highly qualified people with lived experience.

## Career Pathways

A core feature of the peer role is rapport and relationship building with service recipients based on mutual experiences and mentorship. It may be for this reason that most newly emerging peer roles are structured as front-line service delivery positions. Limiting peer positions to front line roles may truncate career pathways and advancement opportunities for peer staff. Because of the stigma associated with peer positions – i.e., being openly identified as a person with lived experience – peer staff may experience challenges in making lateral moves to other positions within their own or other organizations. Additionally, peers may face barriers to promotion because of limited access to professional

development, leadership opportunities, special projects, and other opportunities to prepare for promotion. The challenge of limited career pathways from peer roles has been reported in the literature (Gates & Akabas, 2007; McLean, Biggs, Whitehead, Pratt, & Maxwell, 2009; Salzer, Schwenk, & Brusilovskiy, 2010; TaylorNewberry Consulting, 2014). Among paid peer staff surveyed in Ontario, lack of opportunities for career advancement was the most frequently reported challenge with 59% of respondents identifying it as a moderate or severe problem (TaylorNewberry Consulting, 2014). Although the frequency of this challenge was high across the sample, peer staff who had been employed in their role for more than 2 years reported this as a challenge more frequently than those who had been employed for less than 2 years, which may suggest that hopes of advancement may decline the longer that peer staff are in their roles (TaylorNewberry Consulting, 2014).

## Clarity of Purpose

Since the early 1990's, the creation and implementation of formalized peer positions within health care systems has become an emergent trend (Davidson, Chinman, Sells, & Rowe, 2006; Grant, 2010; Kemp & Henderson, 2012). While many of the earliest peer roles existed within peer-run organizations there has been a more recent trend toward situating these roles within mainstream agencies, and multidisciplinary teams. With the development of these roles in mainstream agencies still in their initial stages, some agencies appear to lack a clear and established purpose for the role. It is uncertain in the literature whether this lack of clarity of purpose is due to a poor or incomplete planning process for a new peer

position on the part of organizational leadership, or is due to failure of the organizational leadership to clearly communicate the purpose of the position to front-line staff. However, such lack of clarity of purpose can act as the seed for all other implementation issues identified in this review.

Peer staff, employers and supervisors have all identified that a lack of clear expectations of peer staff, such as description of roles and responsibilities can be a challenge (Cabral, Strother, Muhr, Sefton, & Savageau, 2014; Moran, Russinova, Vasudha, & Gagne, 2013). When the purpose of peer roles is not clearly communicated across the agency, challenges may manifest in a variety of ways. For example, supervisors and colleagues may not understand the role and may be unsure of how to integrate and support the role (Cabral et al., 2014). When peer positions are structured as isolated functions rather than integrated into the organizational service delivery model, peer staff can be viewed as “add-ons” to existing services and programs (Moll, Holmes, Geronimo, & Sherman, 2009; TaylorNewberry Consulting, 2014).

A lack of clarity about the purpose of peer roles within a mainstream organization can lead to challenges when the practice of peer support, including intentional use of lived experience, bump up against the “legal, ethical and clinical cultural framework” of the organization (Alberta & Ploski, 2014, p. 26). When the culture of an organization emphasizes or privileges professional education, skills and credentials and underemphasizes lived experience (Colson & Francis, 2009; Mowbray et al., 1996; Salzer et al., 2002) peer roles may seem to not “fit” within the organizational culture.

This lack of “fit” may signal that the unique value and purpose of peer roles has not been fully considered. Similarly, organizational practices such as requiring peer staff to adapt to the clinical language and norms of the setting are a challenge that can arise when the purpose of peer roles is not clear (Gillard, Edwards, Gibson, Owen, & Wright, 2013; Moran et al., 2013).

Without a clear understanding of peer positions and their value in the employing agency, peer staff can be seen as ‘tokenistic’ and not taken seriously by employers and colleagues (Moran et al., 2013; Nestor & Galletly, 2008). The peer position can then become undervalued, which may lead to peer staff being tasked with low responsibility or ancillary jobs (Salzer et al., 2010) or working in poorly structured jobs that don’t include regular supervision and training (Health Workforce Australia, 2014).

Critically, when the nature of peer roles is not understood or clearly communicated peer staff may face barriers to practicing peer support effectively. For example, supervisors and colleagues may emphasize ‘boundaries’ in a way that does not acknowledge the unique ways in which boundaries are negotiated in peer relationships (Gillard et al., 2013; TaylorNewberry Consulting, 2014). In some cases, supervisors and colleagues may be unsupportive of, or actively discourage, the use of lived experience (Gillard et al., 2013; Moran et al., 2013).

## Co-optation

With the emergent trend of situating peer staff within multidisciplinary teams, the concept of co-optation has appeared as a theme in several qualitative studies (Kemp

& Henderson, 2012; Repper & Carter, 2011). It is important to acknowledge how the literature is exploring concepts of co-optation, what this means for peer staff, the types of environments that promote this process, and to understand why co-optation can be an important reactive strategy for some peer staff.

According to Repper & Carter (2011) co-optation refers to the risk of peer staff being socialized into professional or clinical approaches to service delivery or helping. Further, Alberta and Ploski (2014) describe co-optation as “the adoption of values, attributes, and style of personal interaction associated with professionally credentialed staff members by peer staff members” (p. 25). Co-optation can be an implicit or explicit process within health care organizations. For instance, language can play a significant role in the process of co-optation, specifically when peer staff are working in settings that are informed by a medical model approach to treatment. Peers may be required or may perceive the need to use clinical or medical language when talking about clients to their team or supervisor. The use of diagnostic terminology may alter their assessment of particular circumstances. This process can be a contributing factor that undermines the unique perspective that peer staff bring to their work (Mead & MacNeil, 2004 in Repper & Carter, 2011). Pressures to adapt to the approaches of other professionals can create tension for peer staff who try to maintain the integrity of peer support while contributing meaningfully to their teams and being regarded by colleagues and employers as providing a valuable contribution (Kemp & Henderson, 2012). This challenge can be exacerbated when there is lack of clarity about the purpose of the role within the organization or a team.

This can contribute to the pressure that peers may experience to adopt more professional ways of working so that their work is better understood and accepted (Colson & Francis, 2009; Repper & Carter, 2010).

While co-optation generally carries a negative connotation, it may also be an adaptive strategy that peer staff employ to mitigate some of the other common implementation issues they experience such as challenging relationships with non-peer colleagues, maintaining good mental health, lack of role clarity, and inadequate supervision (Naughton et al., 2015). At a broader level, co-optation becomes a concern for the entire enterprise of employing peer staff if peer staff end up abandoning the very attributes and approaches which were the reason for employing them in the first place (Alberta & Ploski, 2014).

## Employment Status and Implications for Compensation

From the literature, it appears to be fairly common for peer roles to be structured as part-time or less than full-time positions. As previously discussed, many peer positions in mainstream mental health and addiction agencies are new and some authors have suggested that structuring the roles as part-time reflects employer caution as they adopt these new roles into their organizations (Fisk et al., 2000). Alternatively, the reason for structuring roles as part-time or flexible may be to support the mental health and well-being of peer staff (Gates & Akabas, 2007). There is a need to further explore the structure of

peer staff roles and the implications on staff and client outcomes.

It may be the case that some peers appreciate having a reduced workload, particularly when they are new or returning to the workforce or when they are experiencing periods of mental distress (Gillard et al., 2013). However, research has consistently found that peer staff experience added challenges when they don't have access to full-time work. These challenges may include increased financial stress (TaylorNewberry Consulting, 2014), exclusion from employer benefits (Gates & Akabas, 2007), and colleagues perceiving the role as devalued (Gillard et al., 2013).

Although there is very little quality data about the rates and nature of compensation for peer staff, the limited research that addresses the issue of compensation seems to suggest several patterns: (1) some peer staff continue to earn, on average, less than a living wage, (2) there is considerable variability in compensation rates across the field with little to no standards and criteria, and (3) peer staff continue to receive wages that are not commensurate with non-peer colleagues.

Wages are likely to be insufficient for meeting basic needs when peer roles are structured on a flexible, hourly schedule, particularly when work is contingent on the behaviour of clients, i.e., peer staff are compensated only when the service users they work with show up for appointments (Mowbray et al., 1996). Compensation systems based on education credentials may undervalue the unique contribution of peer staff (Mowbray et al., 1996). However, this assumes that peer staff are less educated than their colleagues. In a survey of peer staff in Ontario, three quarters of paid peer staff had completed post-

secondary education and less than 10% did not finish high school suggesting that lower levels of education is not a sufficient explanation as to why peer staff wages are not comparable to colleagues doing similar work (TaylorNewberry Consulting, 2014). Peer staff's perception of the valuation of their work compared to other colleagues doing similar work may also be an indicator of the adequacy of wage rates. In the same Ontario survey, about half of paid peer staff indicated that they somewhat disagreed or strongly disagreed with the statement, "I feel that my income is equitable with non-peer employees who do the same type of work." (TaylorNewberry Consulting, 2014). When wages are not commensurate with colleagues doing similar work it can lead to the impression of peer support work as being of less value (Mowbray et al., 1996). This may represent an actual undervaluing of the work that peer staff do due to lack of understanding or confusion about the role and the value of experiential knowledge (Fisk et al., 2000)

## Identity Conflict

The process of becoming a peer staff not only involves taking on a new employment role, but for people who have lived experience, becoming a peer staff means disclosing your identity as a person with mental health or addiction issues. When becoming an employee of a health services organization, it may also mean transitioning from a service user identity to a service provider identity, or straddling both. The implications of these transitions are central to many implementation issues.

For many peer staff, understanding who they are and where they fit within an organization is a difficult process. Struggling

with identity conflict can be quite novel when peer staff are hired by agencies where they used to be (or are currently) service users (Gates & Akabas, 2007). Peer staff, particularly those situated in mainstream multidisciplinary teams, have reported that negotiating the sometimes conflicting identities between being a service user and becoming a professional can be a challenge. This challenge has been described by some as not fully being able to claim either the service user or professional identity (Bledsoe, 2001; Gillard et al., 2013; Moll et al., 2009). Navigating these two identities can be particularly challenging when peer staff aim to use their experiences to build meaningful relationships based on mutual understanding while adhering to professional standards of practice (Bledsoe, 2001). This may be particularly challenging when employers and colleagues implicitly or explicitly signal that peer staff are not professional staff, while service users may signal that peer staff are no longer service users either Mancini & Lawson (2009). Peer staff are often asked to transcend both friend and professional relationships without occupying the space of either friend or professional – a task that is neither trivial nor easy. A training manual from an Arizona-based peer organizations states the challenges as, “peer support is about being an expert at not being an expert and that takes a lot of expertise” (cited in Repper & Carter, 2010, p. 5). The challenge may be exacerbated when there is also no clear “peer identity” which can act as an anchor for peer staff that experience challenges related to identity conflicts. The absence of an alternative identity, which may be because of a lack of consensus on what constitutes peer work, can also contribute to

the experience of identity conflict (Gillard et al., 2013).

Trying to negotiate a coherent role identity can lead to some peer staff to express discomfort with wearing the “peer” label. Discomfort may also result from having to emphasise a part of their life that they may want to move on from, or because of the “pigeonhole” effect it has on their life and work. Moran et al., (2013) have explored and noted that the challenge of being unable to “leave the illness identity” behind can have consequences for the recovery of peer staff.

## Isolation

In a sample of Ontario peer staff 28% identified feeling isolated in the workplace as one of the top five most significant challenges for peer staff (TaylorNewberry Consulting, 2014). The literature describes the isolation that peer staff experience in their work as both practical (i.e., working independently with little connection to colleagues) and emotional (i.e., feeling socially and emotionally disconnected from colleagues). Peer staff may experience isolation in relation to their colleagues, particularly non-peer colleagues, as well as a sense of isolation from other peer colleagues (Moran et al., 2013; Repper et al., 2013; TaylorNewberry Consulting, 2014). Isolation can be particularly challenging for peer staff on multidisciplinary teams with only one peer staff (Repper et al., 2013; TaylorNewberry Consulting, 2014).

Organizational practices and culture, such as feeling unsupported by management or colleagues can contribute to peer staff’s experiences of isolation (TaylorNewberry Consulting, 2014). Considering the

multitude of challenges and stresses of navigating issues related to role clarity, boundaries and identity conflict, Mowbray, Moxley, & Collins (1998) note that feelings of isolation are prevalent, particularly if the role is not well understood within the organization. When the peer role is not integrated with other programs or lived experience is not acknowledged as a valuable qualification, peer staff may be vulnerable to experiences of feeling isolated (TaylorNewberry Consulting, 2014).

## Mental Health and Well-being

Maintaining good mental health and well-being is a core implementation issue because peer staff are presumed to be inherently more vulnerable to experiencing mental distress as a result of their lived experience, and because poor mental health is frequently noted as a consequence of experiencing many of the other implementation issues. Like any position in the mental health and addiction field, peer workers report experiencing stress and burnout related to their role. However, peer experiences have a unique set of circumstances that can trigger stress because of the expectation of their active use of lived experience. This often positions peer staff as vulnerable to a multitude of triggers. Manicini & Lawson (2009) support this argument by clarifying recovery-focused work in a 'medicalized' setting often conflicts with core recovery principles, such as person-centered recovery goals, which can lead to emotional exhaustion and burnout.

## Overworked and Overextended

Many peer staff have reported feeling overworked or overextended, which leads to stress and other challenges in maintaining good mental health (Moran et al., 2013; TaylorNewberry Consulting, 2014). Being overworked and overextended may result from a variety of circumstances, for example when the position is not adequately structured to account for administrative time necessary for the work which may lead to increased pressure on peer staff (Kemp & Henderson, 2012; Repper et al., 2013). Another example is peer staff who work part time may be asked to participate in work functions outside of their scheduled work hours (Kemp & Henderson, 2012). In some cases, when there is a lack of clarity about the purpose of the peer position, lack of clarity about role expectations, or undervaluing of the position peer staff may be assigned tasks of little value that appear to be outside of their role (TaylorNewberry Consulting, 2014). Further, some peer staff may work overtime, or at a pace that is unsustainable in an attempt to compensate for challenges in the work place, such as feeling a need to demonstrate one's value to colleagues and employer and feeling guilty for taking sick leave or using accommodations (Bledsoe, 2001).

## Relationships with Non-Peer Colleagues

While there is plenty of evidence that peer staff can have positive relationships with non-peer colleagues and contribute meaningfully to recovery-oriented teams (Cabral et al., 2014), it is also the case that

peer staff experience challenges in their relationships with their colleagues. Challenges in relationships with non-peer colleagues were frequently reported in the literature as an implementation issue for peer staff. This is a multi-dimensional issue that includes: negative attitudes of non-peer colleagues, challenges that arise when working with past or current helping professionals, challenges that result from disclosing to colleagues, the perceived need to “prove” one’s value to improve relationships with non-peer colleagues, and barriers to contributing to the team because of a lack of fit between peer work and the service approach of the team.

**Negative attitudes of non-peer colleagues.** There are concerns in the literature from authors, peer staff, and others that some non-peer colleagues of peer staff may harbour or express negative attitudes toward their peer colleagues (Mowbray et al., 1996). While the manifestation of these attitudes reportedly varies, they can generally be seen as the result of a power imbalance between peer staff and non-peer colleagues. An Ontario survey of peer staff found that 28% of respondents reported power imbalances between peer staff and non-peer staff as a moderate or severe problem, and experienced peer staff reported that this was a significant problem more often than less experienced staff, suggesting that the nature of power in relationships with non-peer colleagues may be better understood over time (TaylorNewberry Consulting, 2014). Often explained as stigma that occurs in subtle and unsubtle ways (Byrne, 2014; TaylorNewberry Consulting, 2014), peer staff report that the negative attitudes of non-peer colleagues manifests as:

- Dismissiveness (TaylorNewberry Consulting, 2014)
- Devaluing the peer role (TaylorNewberry Consulting, 2014)
- Disrespect (Mancini & Lawson, 2009)
- Discomfort with peer ‘boundaries’ (Colson & Francis, 2009)
- Treated through the lens of their diagnosis (Mancini & Lawson, 2009)
- Questioning the actions of peer staff after disclosure (Fisk et al., 2000)
- Assigning low-level work and responsibilities (Mowbray et al., 1998)
- Interpreting emotions as symptoms (Gillard et al., 2013; TaylorNewberry Consulting, 2014)
- Not being invited to participate in social events with colleagues, e.g., lunch (Fisk et al., 2000)
- Changes in tone of voice and demeanour when speaking to peer staff (Fisk et al., 2000)
- Witnessing non-peer colleagues make jokes or demeaning comments about service users (Nestor & Galletly, 2008)

It is important to note that not all non-peer staff have negative attitudes toward peer staff, and many are supportive and see the value of peer positions (Hardiman, 2007 as cited in Health Workforce Australia, 2014). However, negative attitudes mentioned in the literature include beliefs that peer staff are not capable of doing the work because of their mental distress (Cabral et al., 2014), thoughts that peer positions are a way of hiring for lower pay (Cabral et al., 2014; Gillard et al., 2013; Nestor & Galletly, 2008), and seeing little or no value in the use of lived experience in recovery (Health

Workforce Australia, 2014; Nestor & Galletly, 2008).

Whether these experiences, as reported by peer staff, are reflective of the intentions of their colleagues or not, their experience of and consequences of those experiences are real and harmful (Mancini & Lawson, 2009). They can be triggering and stressful for peer staff (TaylorNewberry Consulting, 2014) and have an impact on their well-being (Byrne, 2014).

Several authors suggest that negative attitudes of non-peer colleagues may result from a sense of threat to one's own job and role (Gillard et al., 2013; Mowbray et al., 1996). For example, allowing peer staff access to case notes, and the ability to edit notes may be seen as an infringement into the role of clinical staff (Nestor & Galletly, 2008). This may be compounded when there is limited contact with peer staff due to part-time hours and lack of interaction between peer staff and their colleagues in informal and formal meetings (Moll et al., 2009).

**Working with past helping professionals.** Relationships with non-peer colleagues may be uniquely challenging for peer staff who are hired to work in agencies where they currently or previously accessed services, resulting in a dynamic in which their former (or current) service providers are now also colleagues (Bledsoe, 2001; Fisk et al., 2000).

**Disclosure to colleagues.** For peer staff, negotiating boundaries with colleagues can be challenging, particularly when determining how much of their lived experience they feel comfortable disclosing. Peer staff report that disclosures of their personal history with mental distress has led to changed relationships with non-peer colleagues, for example feeling either

devalued or overprotected (Moran et al., 2013). In some cases, non-peer colleagues may feel a sense of responsibility to support their peer colleagues, for example, if they notice their peer colleagues becoming ill (Gillard et al., 2013). However, for some peer staff, it has been important to learn where to draw the line in terms of disclosures, even with supportive non-peer colleagues as it can contribute to the peer staff being seen more as a service user than a colleague (Moll et al., 2009).

Challenges can arise within these relationships when peer staff are treated as 'patients' rather than, or in addition to, being treated as a colleague (Repper et al., 2013). Another consideration is that peer staff may be concerned about confidentiality issues within their work place with respect to the sharing of their personal information including past and current experiences with distress and service use (Salzer et al., 2002). For peer staff who have negative relationships with non-peer colleagues, the ability to withstand the stigma and discrimination that can result from disclosure may determine which peer staff stay employed versus those who resign (Fisk et al., 2000).

**Need to "prove" your value.** For some peer staff, the negative attitudes of their non-peer colleagues, the fear of colleagues' negative attitudes, or the sense of unequal power compared to colleagues may prompt them to try to "prove" their value (Bledsoe, 2001). Fears related to needing to prove one's value and ability may be particularly heightened when peer staff are returning to work after a leave associated with an experience of mental distress (Kemp & Henderson, 2012).

**Not being able to contribute to teamwork (structural issue).** Integrating into work

teams may be particularly difficult when peer staff are not able to influence the way the team works or do not have the clinical knowledge to contribute according to the existing team norms (Gillard et al., 2013). Trying to integrate into a new team while also having to, or being expected to, challenge attitudes and behaviours that are not recovery-focused can be especially challenging (McLean et al., 2009).

## Relationships with Service Users

Like other helping professionals, some of the challenges that peer staff experience may be typical in the helping relationship, such as being frustrated with the behaviour of service users who show up late or not at all for appointments (Mowbray et al., 1996), or feeling frustrated when service users don't seem to be moving along in their recovery (Moran et al., 2013). However, peer staff may experience unique challenges in their relationships with service users, for example, when working with a person they already know (Mowbray et al., 1996; Salzer et al., 2002) or struggling with gaining the trust or respect of service users because they are a peer rather than a professional (Yuen & Fossey, 2003).

Part of the innate value of peer roles is the potential equalization of power by virtue of the fact that persons in the helping relationship share a mutual experience of mental distress and service use. However, if peer positions are marked by substantial power differences, then there is a very real possibility that the relationships between peer staff and service users may not differ from those of their non-peer colleagues (Mead, Hilton, & Curtis, 2001).

## Resources to Meet Job Requirements

Peer staff may be set up to fail when they don't have access to the basic resources needed to do their job such as a desk, a computer, and access to relevant information about the service users with whom they work. In some cases, peer staff were not provided with basic job orientation that may be expected for any new employee (TaylorNewberry Consulting, 2014). Some peer staff have noted that not having access to information, including client records, because of concerns about their ability to maintain confidentiality was a challenge (Salzer et al., 2002).

## Lack of role clarity

Lack of role clarity is an implementation issue mentioned frequently in the literature. It refers to the uncertainty about one's role including, "duties, extent of authority, allocation of time, relationships with others, and how the employee will be evaluated, as well as adequate guidance from agency policies and procedures" (Davis, 2013, p. 147). Defining peer roles is a noted challenge as they can vary significantly across organizations, incumbents, and settings.

Having unclear role expectations was rated as a moderate or severe problem by 30% of peer staff surveyed in Ontario – the second most frequently reported challenge associated with the role. This was a greater challenge for peer staff who were newer to the role (under 2 years) than those who were more experienced (over 2 years) (TaylorNewberry Consulting, 2014).

Some authors advocate the creation of clearer job descriptions to combat role ambiguity, while others caution that overly prescriptive job definitions may unnecessarily constrain peer staff and inhibit the flexibility that may be needed to do and grow the position. While there is sometimes resistance to formalizing peer roles for fear of over prescription, there are also challenges associated with not formalizing roles, often in terms of lack of role clarity and associated stresses that result (Repper et al., 2013). On the other side, it is also important to not make roles so rigid that they can not be adapted as more is learned about how they fit within an organization, and as new incumbents occupy and develop the positions (Moll et al., 2009). Peer staff roles may change over time as an organization adapts the role (TaylorNewberry Consulting, 2014).

Noted in the literature, lack of role clarity can manifest in a variety of ways, for example, when peer staff are uncertain about the autonomy and authority that they have in decision-making (Mowbray et al., 1996), and when peer staff are assigned to tasks outside of the perceived role (Gates & Akabas, 2007; Gillard et al., 2013; Moran et al., 2013). The challenged can be compounded when peer staff are expected to show up fully knowledgeable about their role and able to explain their role to their colleagues (TaylorNewberry Consulting, 2014).

Lack of role clarity may result when the peer staff position was created without attention to the purpose and value of the role. Even with clarity of purpose and commitment at higher levels of organization, this may not always be translated to the day-to-day operation of programs (TaylorNewberry Consulting, 2014). The degree to which

expectations about the role are communicated during the recruitment process may impact role clarity (Gillard et al., 2013).

The impacts of lack of role clarity for peer staff include job dissatisfaction (Mowbray et al., 1996) and isolation from colleagues (Mowbray et al., 1996; TaylorNewberry Consulting, 2014).

## Supervision

Having access to adequate supervision is important for peer staff (Gillard et al., 2013; Moran et al., 2013). In some cases there may be a distinction between managerial and clinical supervision. Managerial supervision provides feedback on the employee's performance of the role, whereas clinical supervision provides support and feedback for employees engaged in emotional labour. Sometimes peer staff experience challenges when they have one type of supervision and not the other, for example, access to supervisory support in sorting out administrative details, but not access to support in processing challenges related to boundaries with clients (Gillard et al., 2013).

Both peer staff and their supervisors report challenges in providing appropriate supervision for peer staff when the role definition and expectations are not clear. This can make it difficult to evaluate job performance and to provide adequate support and feedback (Cabral et al., 2014; Kemp & Henderson, 2012). This is a particularly difficult challenge if supervisors do not understand the value and centrality of using lived experience to the role and provide feedback that discourages the use of lived experience (Moran et al., 2013).

Being able to talk about lived experience in supervision is important since this is the defining feature of peer positions and can be a challenging tool to use well. Furthermore, some peer staff have identified that being supervised by someone else with lived experience may better contribute to the types of supervisory support that they need (TaylorNewberry Consulting, 2014). Results from the survey of peer staff in Ontario found that although peer staff in mainstream agencies had access to different modalities of supervision, 30% reported being somewhat or very dissatisfied with the supervision they had access to (TaylorNewberry Consulting, 2014). From their findings, the authors of the Ontario study highlight that inadequate, or no supervision can contribute to feelings of isolation and being undervalued in the workplace (TaylorNewberry Consulting, 2014). Conversely, for some employers, supervision may be used as a way to mitigate the perceived risks of peer staff making mistakes in a clinical context (Chinman et al., 2006) and can be experienced as overly controlling providing little autonomy to the peer staff (Moran et al., 2013).

## Training

Peer staff may have opportunities for different types of training related to their work either before (pre-service) or after (in-service) they are hired; however, the types of training peers may receive vary depending on the organization and service sector in which they are employed. The lack of uniformity in training is a noted challenge for some peer staff who are concerned that their peer colleagues are inadequately trained for the position (Moran et al., 2013).

Many peer staff express a desire for more or additional training, which may reflect their own willingness to learn and grow in their role, or feeling unprepared for the demands of the role, which may result from lack of role clarity (TaylorNewberry Consulting, 2014; Moran et al., 2013). Moreover, not providing additional training may be seen as a way of treating all staff equally, but additional training may be important for peer staff who are adjusting to new positions (Gates & Akabas, 2007).

In the literature on peer staff, training is often offered as a solution to many of the challenges that peer staff face, perhaps with unrealistic expectations of what can and cannot be resolved through training. The authors of this review caution that this view of training as panacea can reinforce the misguided notion that the challenges peer staff face are usually, and should be, within their control to change.

## Intentional Use of Lived Experience

Lived experience informs the work of peer staff and the use of lived experience is implied by the nature of the role, but it is not always clear how one's lived experience should be used in a peer role. This issue is significantly underexplored in the literature on peer staff.

An organization may have explicit or implicit expectations about how and whether peer staff use their lived experience in their work. It may be more difficult for peer staff to negotiate this challenging territory when expectations are not explicit and are forced to interpret expectations based on colleague and employer responses to their performance (Fisk et al., 2000). Employers

and non-peer colleagues may have unrealistic expectations about the challenges and strategies that peer staff face when using their lived experience in their work (Colson & Francis, 2009).

The potential benefits of intentional use of lived experience are the unique promises of peer work: it is what sets this role apart from other similar positions (Moll et al., 2009; Repper & Carter, 2010). However, the application of lived experience in peer work also presents unique challenges as it is a type of emotional labour that goes beyond what other helping professionals perform (Mancini & Lawson, 2009).

Challenges related to how and whether to use one's lived experience on the job are often framed by employers and non-peer colleagues in terms of 'boundaries' and what is considered professionally appropriate in terms of sharing personal experience in a professional-client relationship (Fisk et al., 2000; Gillard et al., 2013). However, peer staff offer a more nuanced perspective on the particular challenges of using one's lived experience, including sharing experiences of recovery without making comparisons (Kemp & Henderson, 2012; Moll et al., 2009; Moran et al., 2013), not becoming too self-focused

(Moran et al., 2013), and understanding when it is appropriate to share (Fisk et al., 2000).

Challenges associated with using one's lived experience effectively include the possibility of becoming enmeshed with a service user's experience which can lead to vicarious trauma (Mancini & Lawson, 2009), feeling the pressure of becoming a "poster child for recovery" (Moll et al., 2009), and finally, receiving negative feedback from service users that do not respond well to their experiences of recovery (Moran et al., 2013).

Intentionally using lived experience effectively in a helping relationship with someone else is not an easy skill and requires practice and support. Peer staff develop their own strategies for using lived experience effectively largely through trial and error. Even when using lived experience and negotiating boundaries is addressed in training, there will usually continue to be unique situations that arise and require support in terms of how to handle it (Moll et al., 2009). Peer staff may not have access to training and on-going support in the effective use of lived experience (Repper et al., 2013).

## References

- Alberta, A. J., & Ploski, R. R. (2014). Cooptation of peer support staff: Quantitative evidence. *Rehabilitation Process and Outcome*, 3, 25-29. <http://doi.org/10.4137/RPo.s12343>
- Bledsoe, C. (2001). Unique eyes and different windows of opportunity: The consumer provider perspective. *Occupational Therapy in Mental Health*, 17(3/4), 23-42.
- Byrne, L. (2014). A grounded theory study of lived experience mental health practitioners within the wider workforce. Unpublished doctoral thesis. Central Queensland University, Rockhampton, Australia.
- Cabral, L., Strother, H., Muhr, K., Sefton, L., & Savageau, J. (2014). Clarifying the role of the mental health peer specialist in Massachusetts, USA: Insights from peer specialists, supervisors and clients. *Health & Social Care in the Community*, 22(1), 104-12.
- Chinman, M., Young, A., Hassell, J., & Davidson, L. (2006). Toward the implementation of mental health consumer provider services. *The Journal of Behavioral Health Services & Research*, 33(2), 176-195.
- Colson, P. W., & Francis, L. E. (2009). Consumer staff and the role of personal experience in mental health services. *Social Work in Mental Health*, 7(4), 385-401. <http://doi.org/10.1080/15332980802237735>
- Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 33(3), 443-450.
- Davis, J. (2013). Supervision of peer specialists in community mental health centers: Practices that predict role clarity. *Social Work in Mental Health*, 13(2), 145-158.
- Deegan, P. (2011). *Peer staff as disruptive innovators*. Retrieved from <https://www.patdeegan.com/blog/posts/peer-staff-disruptive-innovators>
- Fisk, D., Rowe, M., Brooks, R., & Gildersleeve, D. (2000). Integrating consumer staff members into a homeless outreach project: Critical issues and strategies. *Psychiatric Rehabilitation Journal*, 23(3), 244-252.
- Gates, L. B., & Akabas, S. H. (2007). Developing strategies to integrate peer providers into the staff of mental health agencies. *Administration and Policy in Mental Health*, 34(3), 293-306.
- Gillard, S. G., Edwards, C., Gibson, S. L., Owen, K., & Wright, C. (2013). Introducing peer worker roles into UK mental health service teams: A qualitative analysis of the organisational benefits and challenges. *BMC Health Services Research*, 13(1), 188. <http://doi.org/10.1186/1472-6963-13-188>
- Grant, J. (2010). Supporting prosumer employment: Results from an ethnography of two Ontario community mental health organizations. *Canadian Journal of Community Mental Health*, 29(1), 81-93.
- Health Workforce Australia. (2014). *Mental health peer workforce literature scan*. Adelaide, SA: Health Workforce Australia.

- Kemp, V., & Henderson, A. R. (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. *Psychiatric Rehabilitation Journal*, 35(4), 337-340. <http://doi.org/10.2975/35.4.2012.337.340>
- Mancini, M. A., & Lawson, H. A. (2009). Facilitating positive emotional labor in peer-providers of mental health services. *Administration in Social Work*, 33(1), 3-22. <http://doi.org/10.1080/03643100802508619>
- McLean, J., Biggs, H., Whitehead, I., Pratt, R., & Maxwell, M. (2009). *Evaluation of the Delivering for Mental Health Peer Support Worker pilot scheme*. Social Research, Scottish Government.
- Mead, S., Hilton, D., Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25(2), 134-141.
- Moll, S., Holmes, J., Geronimo, J., & Sherman, D. (2009). Work transitions for peer support providers in traditional mental health programs: Unique challenges and opportunities. *Work: A Journal of Prevention, Assessment and Rehabilitation*, 33(4), 449-458. <http://doi.org/10.3233/WOR-2009-0893>
- Moran, G. S., Russinova, Z., Vasudha, G., & Gagne, C. (2013). Challenges experienced by paid peer providers in mental health recovery: A qualitative study. *Community Mental Health Journal*, 49, 281-291. <http://doi.org/10.1007/s10597-012-9541-y>
- Mowbray, C. T., Moxley, D. P., & Collins, M. E. (1998). Consumers as mental health providers: First-person accounts of benefits and limitations. *The Journal of Behavioral Health Services & Research*, 25(4), 397-411.
- Mowbray, C. T., Moxley, D., Thrasher, S., Bybee, D., McCrohan, N., Harris, S., & Glover, G. (1996). Consumers as community support providers: Issues created by role innovation. *Community Mental Health Journal*, 32(1), 47-67.
- Naughton, L., Collins, P., & Ryan, M. (2015). *Peer support workers – A guidance paper*. Dublin: National Office for Advancing Recovery in Ireland.
- Nestor, P., & Galletly, C. (2008). The employment of consumers in mental health services: Politically correct tokenism or genuinely useful? *Australasian Psychiatry: Bulletin of Royal Australian and New Zealand College of Psychiatrists*, 16(5), 344-7. <http://doi.org/10.1080/10398560802196016>
- Ontario Human Rights Commission. (2015). *The duty to accommodate*. Retrieved March 28, 2016, from <http://www.ohrc.on.ca/en/policy-and-guidelines-disability-and-duty-accommodate/4-duty-accommodate>.
- Repper, J. (2013). *Peer Support Workers: A practical guide to implementation*. London: Centre for Mental Health and Mental Health Network, NHS Confederation.
- Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R., & Rennison, J. (2013). *Peer support workers: Theory and practice*. London: Centre for Mental Health and Mental Health Network, NHS Confederation.

Repper, J., & Carter, T. (2010). *Using personal experience to support others with similar difficulties: A review of the literature on peer support In mental health services*. London: Together for Mental Well-being and University of Nottingham.

Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health, 20*(4), 392-411.  
<http://doi.org/10.3109/09638237.2011.583947>

Salzer, M. S., Berkey, K., Dodson, J. T., Duckery, W., Rodgers, J., Rogers, S., ... Whitecraft, T. L. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. *Psychiatric Rehabilitation Skills, 6*(3), 355-382.

Salzer, M. S., Schwenk, E., & Brusilovskiy, E. (2010). Certified peer specialist roles and activities: Results from a national survey. *Psychiatric Services, 61*(5), 520-523.  
<http://doi.org/10.1176/appi.ps.61.5.520>

TaylorNewberry Consulting. (2014). *Investigating the state of peer support in Ontario: Findings and implications*. Guelph, ON: TaylorNewberry Consulting.

van den Steenhoven, J., Koh, J., Laban, S., & Geobey, S. (2014). *New Solutions to Youth Employment Lab: First report - draft*. Toronto, ON.

Yuen, M., & Fossey, E. (2003). Working in a community recreation program: A study of consumer-staff perspectives. *Australian Occupational Therapy Journal, 50*, 54-63.