PEER EMPLOYMENT IN THE MENTAL HEALTH & SUBSTANCE USE SECTOR

A Literature Review

Canadian Mental Health Association, BC Division

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Canadian Mental Health Association
British Columbia
Mental health for all

100 years of community

We respectfully acknowledge xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), səl̓ilwətaʔɬ (Tsleil-Waututh), Lkwungen (Songhees) and Wyomilth (Esquimalt) peoples on whose traditional, unceded lands the CMHA BC offices are located.

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INTRODUCTION

Peer employment is a paid work arrangement where an employee or contractor applies their knowledge and experience of mental illness and/or substance use to the performance of their job duties within healthcare, community or social service settings (1).

The history of peer support began over a century ago when recovered psychiatric patients were hired to assist staff at the hospitals where they previously received their care (2). Their roles were often understood as an extension of their treatment rather than a form of employment, even though they were given compensation. This changed with deinstitutionalization. Psychiatric patients were removed from long-term residential facilities and reintegrated back into community (2). Peer support evolved to fill and address the gaps left by a medical system that was failing to provide adequate community-based services to people living with mental health and substance use challenges (2).

Across North America, organized peer support resulted from the mental health consumer movement of the 1970s that empowered former mental health service users to help each other and advocate for themselves (2). Scholars, activists and people who self-identified as psychiatric survivors banded together to counter the powers of the mental health system. These diverse groups were galvanized by a common commitment to human rights and opposed the medicalization of everyday life, from diagnostic codes that disproportionately targeted people who had marginalized identities, to involuntary treatment that sanctioned physical and chemical restraint, to deinstitutionalization that was increasingly pushing ex-patients into deep poverty (3). The motivation for self-determination and freedom from oppressive health care interventions ignited similar movements across the Western world (4). By the 1990s, people who had psychiatric diagnoses began systematically organizing for “mental patients’ liberation” and initiated what is now referred to as the ”c/s/x” (consumer/survivor/ex-patient) movement (5).

Advocacy is central to peer employment. Over the last four decades, the psychiatric survivor movement evolved into a major force for social justice, human rights, and progressive democratic action of various kinds (5). The global movement of people who use drugs grew to address conditions of marginalization and pushed to protect and defend the health of their communities. The jobs created through overdose response and prevention services are only possible today because of the advocacy of earlier groups who fought against and those who continue to fight stigma, discrimination and criminalization (6).

The inclusion of peer workers at every level of the mental health system, and within policy-making bodies that address health and social issues affecting people who use drugs (PWUD), can ensure that policies and services are relevant, equitable, acceptable and meet the needs of the populations they intend to serve (7–9). Interdisciplinary teams that employ peer workers help to increase trust, build relationships and remove barriers between service users and service providers (10). The experiential knowledge that peers possess facilitates a more authentic connection with their clients that is rare among other professional carer relationships (11). Their lived experience inspires hope, encourages empowerment and self-advocacy, and fosters empathy and connectedness through equal relationships (12, 13). Peer roles can also foster compassion and understanding among non-peer professionals and help to alleviate the stigma that often surrounds people with mental health diagnoses and by extension themselves (14).

Peer workers benefit from their work. They gain confidence and self-esteem from performing jobs that are valued and viewed as socially important, which leads to increased feelings of empowerment and autonomy (10, 15, 16). Equitable employment can lead to greater financial security and provide an opportunity for peer workers to build their capacity and expand their professional skills, which can open doors to other employment opportunities (10, 15, 17). Qualitative studies have found that peer participation increases their social networks and promotes feelings of social inclusion through working together and collaborating with others (8).

Peer employment provides an opportunity for people with lived and living experience (PWLLE) to perform meaningful work that helps others and gives back and contributes to the community. Increased feelings of social responsibility that come from belonging to a group can lead to a reduction in socially harmful behaviours (e.g., theft, vandalism) and an increase in civic engagement (15). Peers are empowered to advocate for policy changes and mobilize others to get involved in social justice movements (15). The inclusion of PWLLE as active participants in the development and provision of social programs can shift community perceptions and challenge harmful stereotypes and misconceptions (10).

To fully experience these benefits, however, peer employment must be done in an equitable, accessible and safe way where peers are treated as equals, respected and share decision-making power. Unfortunately, the history of peer employment is marred by inequitable and precarious working conditions. Peer workers often face issues such as insufficient pay, high rates of burnout, discrimination in the workplace, and 'tokenism' (20–22, 31), where organizations involve peers to appear more inclusive yet provide limited opportunities to participate fully in decision-making processes (9). If peers are not meaningfully engaged, workplaces run the risk of re-creating conditions of social exclusion, inequity and systemic harm that many PWLLE already face outside of the workplace (23).

The benefits to peers, service users and broader society demonstrate the importance of involving PWLLE at every level of the mental health system; however, efforts to meaningfully employ peers often fall short of this ideal. This literature review seeks to better understand the core values and current practices of peer employment, the barriers to equity that peers experience within workplaces, and the best practices for creating equitable and supportive working conditions for peer workers.

Methods

The research process was initiated in March of 2021 and concluded in July 2021. A wide range of both academic and grey literature (e.g., journal articles, reports, guidelines, policies, tool kits, etc.) pertaining to peer employment practices was included in the review. The literature search was conducted by entering keywords such as "peers," "people with lived/living experience," "mental health," "substance use" and "employment" into the Simon Fraser University's Community Scholar Program's database and Google Scholar that retrieved articles from several journals (PubMed, JSTOR, PsycINFO, SocINDEX, Journal of Social Work). Additionally, grey literature was sourced from the websites of mental health and substance use organizations, advocacy groups and research institutes in high-income, English-speaking countries (e.g., Canadian Institute for Substance Use Research, BC Centre for Substance Use, Canadian Association of People who Use

Drugs, Mind UK, Mental Health America, etc). All relevant literature published in English between 2010-2021 was included in the review. A total of 54 sources were included.

Notably, the literature did not address peer employment for persons of marginalized identities. Studies did not disaggregate their findings based on Indigeneity, race or gender or they failed to collect demographic information of participants. Papers that synthesized other studies failed to apply a gender-based analysis (GBA+) to their collation or interpretation of the data. This represents a significant gap within this literature review and the larger body of research on peer employment.

Another significant gap identified in the literature is a lack of analysis on the systemic barriers to peer employment. The majority of research conducted in this area points to working conditions and ways in which employers can create more equitable workplaces for peers; however, most of the research stops short of exploring the ways in which the mental health and substance use system can be improved overall to support peer employment and co-production. This is where the Canadian Mental Health Association BC Division (CMHA BC) hopes to fill a gap in the literature with this research project.

THE CORE VALUES OF PEER EMPLOYMENT

The following core values have been derived from themes that were determined through this literature review.

- **Collaboration and equal participation:** Peers and their non-peer colleagues share power through non-hierarchical, reciprocal relationships that blur the distinctions between service providers and service users and give everyone on a professional team a distinct role (7, 10, 24). In practice, this means "doing with" rather than "doing for" by supporting peers to use their own skills and resources to achieve positive outcomes for themselves and their communities (7, 10, 24). This value aligns with the notion of "nothing about us without us" that organizations led by people who use drugs (PWUD) have long advocated for (25, 26).
- **Social inclusion and positive relationships:** Social inclusion is the act of helping people establish a sense of belonging in their community and fostering supportive relationships between peers and their non-peer colleagues, service providers and service users, and among peers themselves (7, 12, 15, 25).
- **Recognition of individual contributions:** This practice involves recognizing and appreciating the value of different types of expertise, knowledge, strengths and abilities that individuals bring to a team, especially those acquired through lived and living experience (7, 10, 15, 22). Another term commonly cited to describe this practice is an "assets-based approach" (7).
- **Strength-based and capacity-building:** Capacity-building is the act of providing opportunities for growth and personal development (10, 12, 23, 24), empowering peers to be involved in decision making (15, 23, 27), and creating networks for peers to share knowledge and support each other in navigating the formalized work environment (7, 10, 24).
- **Harm reduction and holistic recovery:** Organizations that employ peers often express a commitment to upholding a harm reduction philosophy (15, 23), and in the case of mental health peer work, view the concept of 'recovery' holistically. Rather than meaning a "cure" or elimination of symptoms, recovery focuses on an individual's quality of life with regard to their relationships, community participation, and sense of wellbeing and empowerment (12).
- **Self-determination:** This is the promotion of a person-centred approach, shared decision-making, and trust that each person can make their own decisions and knows what path is most suitable to meet their needs (7, 12, 25).
- **Elimination of inequality:** This is done through advocacy (12) to promote social justice (28) and human rights (15) and reduce health and social inequities (23, 28).

In addition to core values, many reports highlight the significant barriers that peer workers face in obtaining supportive and equitable working conditions. These barriers, which are further described in the following sections, reveal that many organizations employing peers struggle to uphold these core values and still have a long way to go before these ideals can be reached.

WHAT DOES PEER EMPLOYMENT LOOK LIKE?

Sectors and Settings

Peers are employed across a variety of sectors including government, health and social services, the criminal justice system, non-profit organizations, research institutes and peer-led groups (29, 30). Their work occurs across various settings and locations that include clinical settings (12) e.g., hospitals, clinics, detox facilities (29), Assertive Community Treatment teams (11, 13, 16, 22), community (12), clients' homes (30), supportive housing (29), street-outreach, supervised consumption/overdose prevention sites (31), recovery centres, workplaces (12), and institutions such as prisons and jails (29). Working within healthcare settings is more common among mental health peer workers, whereas substance use peers are more likely to work in research, street outreach, supervised consumption and harm reduction services (31). Peers may work independently, with other peers or with non-peer colleagues on interdisciplinary teams (11, 32).

Peer Roles

Peers occupy a diverse range of roles within the workplace (11). The role most commonly associated with peer work is a peer support specialist, where a peer works one-on-one or with groups of people experiencing mental health or substance use challenges to provide practical, social and/or emotional support (12, 13, 18, 30, 33). Family peer support workers provide similar support to the family members of PWLLE (31). Support can be short-term, such as in the case of crisis intervention, or can involve ongoing, longer-term support to help clients work towards their health and wellness goals (1, 12, 29, 34). Peers who have lived and living experience of substance use also commonly work in support roles for supervised consumption and overdose prevention services or as facilitators for abstinence-based peer groups such as Alcoholics Anonymous (21, 31). Organizations will frequently employ peer navigators to assist people in accessing health and social services and to help bridge the gap between service users and service providers (30, 31). Peers can work as educators, facilitating knowledge exchange on topics related to mental health and substance use (11, 31, 35) or researchers, conducting community-based research on topics related to their lived experience (21, 30, 31). Many organizations also engage peers in advisory roles where they are given an opportunity to provide input on the development and implementation of programs and policies (18, 21, 28). Peers may also perform leadership roles, typically as peer supervisors or coordinators of peer-led groups (22, 30).

Although each of these peer roles are identified within the literature, the vast majority of reports focus solely on peer support positions and indicate significant power imbalances between peer and non-peer staff. The reality is that peers are most commonly engaged at the service delivery level of the mental health and social care systems (18); however, many of the authors contend that real, systems-wide transformation necessitates meaningful PWLLE engagement at every level of the system including the planning, development, and evaluation of services, policies, and programs (7, 10, 24). A true sharing of power cannot happen until peers contribute to the decision-making processes that shape the policies that most impact their lives (23, 27).

Meaningful inclusion of peers would no doubt have a transformational effect on service provision, improve work environments and lead to greater peer influence (35). Most of all, inclusion could address the power imbalance between peers and non-peers (17) and increase employer receptivity to peer advocacy (35). In a survey conducted by Austin et al., participating organizations recommended that special care should be taken to provide leadership roles for historically disempowered peers such as people who use drugs (PWUD) and Indigenous peers (17).

Another barrier is the lack of leadership positions and opportunities for career advancement available to peer workers (27, 30, 35). This hinders the ability of organizations to truly shift the power imbalances that exist between peer and non-peer staff. (31). In a 2014 study that surveyed peer workers, conducted by Taylor-Newbury, a majority (59%) of those interviewed cited limited opportunities for advancement as one of the primary complaints about their career (30). The absence of peer leadership roles may also contribute to the dissatisfaction many have with supervision (30). Reasons for this dissatisfaction are explored in an Ontario study that found peer support workers expressed a desire to have supervisors with lived experience of mental illness who had a better understanding of the nature of peer work (30). In another study by Rebeiro Gruhl et al., peers expressed a similar concern that the value of authentic peer support could be lost if their roles and responsibilities are determined by non-peer supervisors (16). The National Consumer Panel recommends recruiting more PWLLE for supervisor roles since their experience offers valuable insights and a unique skill set for managing peer positions (22). Peer roles can help to prevent tokenism and lead to greater recognition of the value of lived and living experience (27). Such opportunities for career advancement may lead to improved job satisfaction and greater economic wellbeing for peer workers (20).

Dedicated roles for peers in management are a recent development. These positions afford peer workers greater influence to shape peer programming and other mental health services (35). Supervision by fellow peers is not only preferred by peers themselves but also important to ensure accountability from the organization to provide a good working environment (14). Byrne et al. found that peers in management positions were able to leverage their authority to inspire change in policies and employment practices and promote peer advocacy (35). The inclusion of peers in management positions signals general acceptance of peers and acknowledges the value lived experience brings to the workplace (35). Chapman et al., however, point out that career advancement should go beyond supervisory positions, citing some organizations that have gone further to establish multi-step career ladders and provide tuition reimbursement for peers looking to further their education (29). Efforts should be made to recruit PWLLE who have previous peer work experience into non-peer leadership roles by explicitly including this as relevant past experience on job postings (22). While organizational commitments are imperative, some States within the US have found regulation and policies to be an effective tool for helping to promote the career advancement of peer workers (29).

Peer Responsibilities

Peer worker job duties vary widely depending on the role and setting they work within (25, 31). A significant component of many peer worker jobs is relational tasks such as building trusting relationships (16, 32, 36, 37), offering mentorship (30, 36) and social support (12, 22), reducing

social isolation for their clients (1, 32, 33), and helping their clients to re-establish social networks (1). Those working within peer support roles often draw upon their lived experience to promote hope, model wellness and recovery, and share their personal experiences with clients (16, 20, 32, 36, 37). Much of the peer role relates to empowering others (32), promoting self-determination (20, 36), encouraging clients to be active participants in their own care (32), and advocating on behalf of their clients and their community (1, 12, 36, 37). Some peers are responsible for directly delivering care (31) in the form of emotional support (1, 29, 30), suicide risk assessments (38), in-patient visits (38), informal counselling (22), guidance, symptom management, and self-care (1, 13), wellness coaching (29), recovery planning (30, 32, 34) and facilitation of recovery-oriented groups (39), crisis management (12, 20, 30) and harm reduction services (17, 31). In addition to delivering care, peers are involved in facilitating access to care by helping people navigate (12, 17, 30) and connect to services and resources in their communities (32, 34, 36, 37), making referrals to housing, jobs and other resources (30), acting as a liaison between clients and non-peer providers (32), and providing case management (29, 38). Other peer workers are involved in helping clients with practical tasks such as accompanying them to appointments (29); providing transportation (12); assisting with household management, personal care (22), daily living activities (13, 22), budgeting (13) and food security (12), and offering assistance with access to public services (20) and vocational support (12, 20).

Many of the tasks that peers perform are educational such as facilitating training (29, 30, 37), providing information (30), raising awareness (30, 37), combating stigma (36) and discrimination (12), and contributing the peer perspective to internal staff education (30). Education is central to peer support since it involves teaching clients skills for coping, problem solving (32), setting goals (1, 34, 36, 38), communicating (1, 34), and managing finances (20, 29). The job of a peer researcher can involve collecting and analyzing qualitative data including conducting interviews and focus groups with PWLLE (22, 37). Peers that hold advisory roles are typically responsible for advising on policy documents and attending meetings to provide their input, raise any concerns and offer feedback on programs and services (21, 22). Administrative tasks (16, 30, 37) such as client paperwork (1), documentation (16, 29) and intake procedures (20) are common to a range of peer positions. Some roles are responsible for financial tasks such as managing bursary funds (34). Lastly, the responsibilities of peers who hold leadership positions often include supervising and overseeing the work of other peer workers, leading PWLLE groups (22), coordinating peer support programs and matching clients with peer workers (1).

While the literature provides general insight into the typical responsibilities of various peer positions, many reports cite a lack of role clarity to be a major issue that many peer workers face (13, 16, 22, 30, 40). With the exception of ACT teams where peers are reported to have more clearly described roles that are recognized by their colleagues (13), oftentimes peer worker roles, responsibilities and expectations are not adequately communicated to them or the rest of their team, which contributes to a range of problems in the workplace (8). Without a clear understanding of their role, peer workers find it difficult to know what the expectations are for their performance and how they can draw upon their knowledge and expertise to accomplish tasks (22, 40). A study by Rebeiro Gruhl et al. found that when the scope of job duties for peer workers had not been clearly defined by their employer, they experienced greater challenges in setting and maintaining boundaries in the workplace (16). Challenges with setting limits and boundaries are more likely among those who are newer to their roles (31) and may contribute to peer workers experiencing higher rates of

burnout and excessive workloads (16). Moreover, a lack of clarity around peer roles can lead to the undervaluing of peer positions from non-peer colleagues, as they may not understand how peers fit within the team or recognize the importance of their contributions (30, 37). Edan et al.'s study reported that among the peers they surveyed, there was a belief that workplace processes were built around more traditional health care positions and bio-medical models of treatment, which led to confusion on the role of peers and inhibited their ability to provide appropriate levels of support to their clients (41). These issues highlight the importance of clearly defining and communicating peer roles and responsibilities to peer workers and the rest of the organization. Non-peer staff often have concerns that the implementation of peer roles such as peer workers will replace non-peer positions, lead to a devaluation of the non-peer labour force and undermine professional boundaries (1). These concerns can be alleviated by providing education on the roles, responsibilities and limitations of peer roles as well as clearly outlining the value of peer positions in the continuum of care (1).

To achieve greater role clarity, Edan and colleagues recommend that organizations create clear job descriptions that reflect peer worker values and put mechanisms in place to ensure the work peers are assigned aligns with these descriptions (41). Moreover, employers should explain their reasons for including PWLLE in a project (26) and put their expectations of peers into writing, including how they will contribute to decisions, the scope of the project, lines of communication, and the support, resources and training they will receive (23). This can help to foster a sense of empowerment and responsibility and enables peers to contribute in a meaningful way, avoiding tokenization (22).

Employment Status

The majority of peer workers are part-time employees, with one BC survey of 200 peer workers finding that only 26% reported full-time employment (31). In the same study, 22% of peers reported working in casual or volunteer positions. The peers who volunteered were significantly more likely to work within the substance use sector, identify as an ethnic minority and not have a university degree (31). Other studies suggest that non-standard work arrangements that are casual, informal and short-term are the norm for many peer workers (21, 23). Many peers also report engaging in sporadic volunteer work, which often involves completing one-off tasks in exchange for a small stipend (21).

The lack of full-time positions and the casual, short-term nature of peer work was found to be associated with a number of barriers. Many peer workers would prefer to work full-time but have difficulties obtaining sufficient hours, which causes financial stress and limits their ability to achieve financial security (30, 42, 43). Some peer workers believe that the lack of full-time positions is partially due to employers' hesitancy to provide them the benefits that full-time employees are entitled to receive (29). Short-term engagements do not offer the same opportunities as longer-term employment for achieving stability, building peers' capacity and developing trusting relationships between peers and non-peer staff (23). Additionally, one-off engagement opportunities are seen by some as 'tokenistic' since they do not actually share power or include peers in decision-making (23). Some peer workers also perceive volunteerism as a threat to the credibility of the workforce, signifying the devaluation of peer positions in the mainstream mental health system and posing a challenge to integration (16).

Some reports, however, spoke favourably of the flexibility of non-standard work arrangements. Casual, cash-based work was preferred by some peers as the flexibility allowed them to fit work into their schedules and life circumstances without the commitments of longer-term employment (21). A low-barrier, informal option for earning a supplementary income was especially important for peers who are receiving income or disability assistance since nominal amounts of compensation do not have to be reported and did not put them at risk of clawbacks on their monthly cheques (21). In the case of volunteering, some peers considered the work to be a meaningful occupation that served as a way to try out a position and gain the skills and confidence to successfully transition into employment (16, 30). Additionally, some peers report that they prefer to work limited hours and choose part-time positions as a way to promote greater balance, reduce stress, and have more time to focus on their own health and wellbeing (13, 29, 30).

The wide variety of preferences and life circumstances among peer workers points to the need to offer a range of employment options and choices. Peers who want to work full-time should have the opportunity to do so, and those who prefer greater flexibility or require a low-barrier way of earning income should have access to part-time employment or casual, cash-based work (21). To avoid a sense of loss at the end of a project, employers can set a wrap up plan with clear expectations at the start and make an effort to continue engaging peers and offering other employment opportunities after the project wraps up (23).

HOW ARE PEERS HIRED AND TRAINED?

Recruitment

People with lived and living experience should be involved in projects from start to finish, yet organizations often wait to invite peers at a later stage when most decisions have already been made. To address this, the Mental Health Commission of Canada's National Consumer Panel suggests organizations establish a plan or "blueprint for the inclusion of PWLLE," which outlines a process for peer involvement throughout the entire lifecycle of a project (22).

Organizations that employ peers typically recruit them using job postings or flyers, through word of mouth, or by employing previous service users or volunteers (23, 30). The BCCDC recommends working with local peer-run organizations who are able to assist with the recruitment process or provide guidance on the best approach (23). In order to ensure there is diverse representation and shared power on a team, the BCCDC highlights the importance of critically examining who is currently at the table and which voices are missing. This information should guide the recruitment process (23). Byrne et al. similarly identify the importance of establishing relationships with organizations that have a significant amount of experience employing peers to gain a better understanding of peer work and successful peer role implementation (35). Employers need to be mindful of and make efforts to address potential barriers to participation, such as location, travel, childcare needs, literacy, and substance use (23). Baker et al. recommend meeting PWLLE where they are at, including at organizations in the community and on the street (26).

Peer positions should have a formal job description that outlines the job title, rate of pay, and required competencies, with equal importance placed on lived/living experience as typically placed on formal education in other roles (40). An explicit acknowledgment of the value of lived/living experience during recruitment is especially important since some peer workers may feel reluctant to disclose their mental health challenges during the application process (30).

Requirements

Lived and Living Experience

The types of lived experience, education and training, past work experience, and attributes that are required for employment vary (30). Peers working within the substance use sector are required to have either past or present lived experience of substance use (28). To work within the mental health sector, peers are required to have lived experience of a mental health challenge or illness, or in the case of family peer support, have a family member or loved one who has that experience (12, 30, 45). Some employers require mental health peer support workers to be in a "positive state of recovery" as this is seen as important for their ability to provide peer support. Recovery does not mean "cured" but refers to their ability to develop tools for resiliency and self-care that enable them to maintain a sense of wellness, hope for the future and confidence even if they still manage symptoms of a mental illness (12). Some organizations take this a step further by requiring documentation from an

applicant's psychiatrist or case manager confirming their stability and ability to do the work (1). Additionally, some employers require peers to have direct experience with the mental health system through accessing services (1, 30, 45).

Attributes

Peer workers are required to have attributes or skills related to interpersonal communication (1, 30) such as being patient, empathetic and supportive, working with culturally diverse populations (1), collaborating and working cooperatively within teams (1, 12), and delivering person-centred, trauma-informed care (36). Employers also require peer workers to demonstrate reliability (12), be organized, exhibit flexibility, have sound judgement (1), exercise critical thinking and uphold ethics (12). Due to the nature of peer work, important prerequisites for employment are strategies to cope with stress (1), self-care practices and healthy boundaries (30). Additionally, a BC survey found that peer support workers considered compassion and care, empathy and authenticity to be the top three most important attributes for their role (31). Skills relating to appropriate self-disclosure, communication, non-judgemental listening, and accountability were also reported as pertinent in a qualitative study of peer support workers in Australia (38).

It is important to note that sometimes the unique skills and experience that peer workers bring to their roles go unrecognized and undervalued. For example, in a national survey of PWLLE working in harm reduction, participants reported that, despite the vital role of informal peer support in the community, providing harm reduction services and supplies to those who do not access official services was not recognized as an employment skill and did not qualify an individual for funding or support (17).

Education, Training and Job-Related Experience

Peer workers bring various types and levels of training to their work (34). A 2014 study on peer support work in Ontario found that education and training requirements for peer positions varied, with employers either requiring some post-secondary education, high school completion, or most commonly, no minimal educational requirements. About half of the 154 peer workers surveyed reported that past job-related experience, as well as specific training and/or certification were considered necessary qualifications for their position. Employers typically provide this training for peers upon hiring, so prior experience and training are commonly considered an asset for job applicants, not a requirement. Areas of training that are most often provided include training on crisis intervention, suicide prevention, first aid and CPR (30), and specific peer support training programs (1), including Wellness and Recovery Action Planning (WRAP), Pathways to Recovery, OPDI Peer Support Core Essentials, and Peer Recovery Education for Employment and Resilience (PREFER) (30).

Although the majority of employers provide on-the-job training and do not have minimal educational requirements (30), other reports claim that the mainstream mental health system is perceived by peers to be less accepting of lived experience as a valid way of "knowing" (16, 22). Similar sentiments are echoed in a study that documents peers' concerns that their colleagues will not respect or take their role seriously without formal training or accreditation (31).

Barriers to Employment

Some employment requirements are discriminatory and exclusionary in nature, serving only to reinforce barriers to employment that many PWLLE already face. Practices such as requiring abstinence and refusing to employ individuals with a criminal record are two such examples (15, 40). An employer's decision to hire should be based on whether or not the individual is capable of fulfilling their job duties. Drug use or a criminal record, in and of themselves, do not have a direct bearing on an individual's capabilities and should not be a significant consideration for hiring (15, 40). A commitment to non-discriminatory hiring practices is a necessary step towards achieving equity and inclusion for peers in the workplace. Balian and White point out that some staff may be uncomfortable with this (e.g., staff who formerly used substances and are trying to maintain abstinence) so employers should make it known that the organization is dedicated to hiring people who use substances and support staff that feel triggered to employ coping mechanisms (15).

Training

Evidence shows that peer workers generally show enthusiasm for training (29, 31), rate the training they receive highly (31), and believe training provides opportunities for networking (29) and helps them to prepare for their roles (30). Research from Australia, however, suggests that a significant proportion of peer workers do not feel as though they have been given enough training to be successful (41).

Training Content

The training that peer workers receive is typically provided on-the-job (30) and covers a diverse range of topics relating to mental health and wellness (12, 30, 31, 38), harm reduction (26), ethics (30), communication (13, 26, 31, 37), motivational interviewing (38), facilitation and managing group dynamics (1, 38), peer support (12, 30, 37, 38), crisis intervention (13, 31), suicide risk assessment (38), referrals and service navigation (12, 37), boundary setting (13, 29, 30, 37, 38), self-determination (12, 31), person-centred practice (38), diversity and inclusion (22, 30, 31), cultural awareness, human rights (38), leadership (22, 26, 27), and workplace skills (13, 26, 29). For more details and information on the content of peer worker training, see the "BC Campus Peer Training Curriculum Study" final report (31).

Training Methods and Delivery

Evidence suggests that peer workers typically learn best from training that utilizes a combination of learning modalities and activities such as lectures, role play, group discussions, online video modules, personal reflections, job shadowing and practicums (12, 31). Diverse methods accommodate different learning styles (12) and address the fact that some peer workers experience challenges learning solo from written materials alone (31). Similarly, much of the literature stresses the importance of keeping training interactive and participatory and providing opportunities for hands-on experiential learning, as this helps peers to develop their skills as they apply the knowledge they have learned (12, 15, 31).

The number of hours of training that peer workers typically receive upon hiring varies widely, with most Canadian training programs ranging from 18-72 hours and followed by a practicum

(1, 34). Similarly, training ranges between 40-75 hours in some US states (29) and increases to 200 hours in a number of European countries (18). The duration of training also varies, with some organizations offering condensed and continuous training over the course of a week, while others spread the training out in separate 2–5-hour sessions over a longer period of time (1, 12, 16). A number of reports, however, highlight the benefit of offering peers the option of spreading their training out over time since processing large amounts of information in a short period of time can be difficult (12, 15, 37).

Opportunities for Ongoing Training

While the bulk of training typically occurs during the orientation most peers receive upon hiring, a need for more ongoing training and professional development was emphasized throughout the literature (12, 16, 18, 31). This may be especially true for casual or contract workers. Ranger found that those employed in longer-term full-time or part-time peer support positions were more likely to have received a wider variety of training (31). Many peer workers are entering back into the workforce with minimal vocational training after a period of unemployment, yet these unique circumstances are often not taken into consideration (41). In several studies, peer workers report having less access to ongoing training and professional development opportunities, mentorship, and supervision than their non-peer colleagues (31, 41) and express a desire for additional and more continuous learning opportunities to support them in their roles (18, 30, 31). In one study, Jones et al. found that almost 79.6% of the peers they interviewed wanted a post-secondary credential, 79.8% were interested in peer certification and 90.2% expressed interest in receiving post-secondary credits for their work (46). Employers saw this desire as an opportunity to provide incentives that would engage peer workers and improve retention (37). The provision of ongoing professional development was considered a way for peer workers to further develop and maintain their skills, continue to build their capacity, and network and exchange knowledge with other peers (12, 37). Avenues suggested for delivering ongoing training include annual workshops (12), weekly training sessions (37), workplace check-ins (31), one-to-one or group supervision meetings (29), and peer worker networks or communities of practice (12).

Accessibility of Training

Research suggests that there are a number of barriers related to the accessibility of peer worker training that employers should be mindful of and take steps to address. Acceptance into a peer support training program can be a competitive and demanding process, as some require applicants to submit a resume, application form, multiple letters of reference, and a criminal record check (34). The accessibility of the curriculum itself can also be an issue. In a 2020 study, BC peer workers reported having challenges understanding some of the vocabulary used in the training they received (31). More broadly, some peer workers may have lower literacy levels or language barriers that make it more difficult to read and understand written training materials (15). A common solution is to offer flexible pacing and progression of training to allow peers to take the time they need to fully comprehend and integrate what they are learning (12, 37). Balian and White (2010) recommend including sufficient breaks and offering refreshments during training sessions since hunger makes concentration difficult and some peers may experience food insecurity or lack proper nutrition (15). It is also important to consider the location of training. Many peer workers use public transportation so training should be held at an easily accessible site (1). Finally, access to

consistent training opportunities is lacking within smaller towns and rural communities, highlighting the need for training to be expanded to these areas (16).

Certification and Credentialing

A number of studies examine peer worker perceptions towards credentialing and certification. The majority of peer workers within these studies view credentials and certificates favourably, believing they are an opportunity for professional development that could help them gain greater acceptance within the mental health system (16) and validate their qualifications to their employers and colleagues (30, 41). Some peers reported that working closely with other peers who lacked the same level of training resulted in having to take on more responsibility, as well as systemic damage to the reputation of peer workers (11). Research confirms that for some peer workers, credentials can improve their confidence and self-esteem, and advocates believe certification leads to the professionalization of the workforce, higher wages and the establishment of training standards that ensure high-quality care and services (29). Others who are opposed fear it is a barrier that could limit some peers from entering the field. These critics voice concerns that certification may lead to the over-professionalization of the workforce and subsequently jeopardize the authenticity of peer support (29). Moreover, in the US, issues arise when states have different training standards and certification requirements. Peer workers encounter difficulties transferring their credentials between states; however, some states have begun to address this through the International Certification and Reciprocity Consortium (29).

The literature references different models of certification and approaches to implementation. Certification is most commonly offered to peer support workers in the mental health sector rather than the substance use sector (18, 29). Programs often have a classroom learning component with an examination and a practicum for gaining hands-on experience (1, 34). In Canada, Peer Support Canada is a national agency that provides certification for peer supporters. Although the certification is optional, completion signals to employers that an individual possesses the skills, knowledge, and experience that align with a nationally endorsed standard of practice for the effective provision of mental health peer support (47). The $1280 cost, however, presents a barrier for many peer workers. At the provincial level, BC Campus recently developed an open-source peer support provincial training curriculum and standards of practice. Their educational resources are free of charge and available to anyone looking to gain peer support knowledge and skills (48).

In Germany, a 200-hour peer support training called “Experienced Involvement EX-IN” was developed for mental health peer support workers. Several other European countries have adopted and implemented this training and hired facilitators within their own organizations to deliver the EX-IN curriculum (18). In the US, peer support workers are often required to complete a state-approved certification program before their services are eligible for Medicaid coverage. Implementation varies between states. Some states approve one organization to provide standardized state-wide training, whereas others have multiple training vendors that deliver a curriculum that is either specified by the state, adheres to core competencies outlined by the state, or is reviewed and approved by the state (29). At the national level, Mental Health America recently established a ‘National Certified Peer Specialist (NCPS)’ Certification to establish a national standard for the training and competencies of peer support workers; however, the NCPS is a voluntary, examination-based certification that does not replace, but is considered additional to, required state certifications (49).

HOW CAN WORK ENVIRONMENTS BE EQUITABLE AND SUPPORTIVE?

Compensation

Equitable Wages

Peer positions are considered by some to be a cost-effective way to improve services; however, this view has led to inequitable wages that have benefited organizations at the expense of peer worker wellbeing (44). A number of reports highlight insufficient pay and difficulties securing a livable wage as one of the greatest and most common barriers that peer workers face (30, 31 40, 43). Peer workers are often paid less than their non-peer colleagues (30, 33, 46), and in some cases are the only people around the table who are not paid at all (26, 31). There is also a pay imbalance between peers who use drugs and peers who do not. Peers who use drugs also experience limited access to benefits compared to other peers who are doing the same tasks (17). Inadequate compensation leads to greater financial stress (23) which is heightened further when peer workers are given limited hours to work (44). Moreover, low wages can give the impression that the work peers do is not valued (50) and can create unequal power dynamics that cause tension and resentment within a team (23). Peer workers should receive livable wages that reflect the immense value they bring to the team (31).

To address some of these issues, the BCCDC developed a set of peer payment standards for short-term work. These guidelines suggest that peers should receive $25/hour for attending meetings, reviewing documents or engaging in other advisory tasks. For engagements that are under 1-hour, peers should still receive the full $25. For peers who provide peer support to other peer workers, they should receive $30/hour. For presentations and facilitation engagements, employers are advised to compensate peers at $50/hr. If the work peers perform is task-based, employers are advised to ensure compensation minimally meets the BC Living Wage and reach an agreement with the peer on the minimum and maximum number of hours at the onset. For employment or contract work, peers should be paid wages with applicable benefits that are comparable to similar non-peer positions (28).

Additional Expenses

Depending on the nature of the peer engagement opportunity, there may be additional expenses that could pose a barrier to participation. Employers are advised to cover these expenses wherever possible, which may include costs related to telephone usage, childcare, or travel (e.g., public transit, gas/mileage, parking, etc.) (23, 28). Since these costs are not considered income, they do not impact maximum earning exemptions for peers receiving disability or income assistance (28).

Payment Processing

Peer workers are most commonly paid by stipend/honorarium or by the hour, with fewer receiving salaries (17). It is important to ask peers how and when they would like their payment processed and provide them with options so they can choose the most suitable payment method for their

circumstances (28). For short-term, temporary engagement opportunities, it is best to pay peers with cash honorariums and refrain from using bills greater than $20 since some businesses do not accept these (28). Access to cash-based work may be especially important for peers who do not have a bank account and cannot process cheques or e-transfers, as well as for those that are receiving disability or income assistance and are subject to earning limits and reporting requirements (17, 21). For peer workers that are located out of town, e-transfer may be a suitable alternative, but a peer worker should have the option to request a cheque instead and receive information on the estimated processing time. Some organizations compensate peers with gift cards; however, this practice is discouraged since it can come across as patronizing i.e., the employer is dictating how a peer worker spends their earnings. If possible, honorarium payments should be issued in private as it can be uncomfortable if peers are the only ones receiving them (28). For peers that are hired as contractors or employees for longer term engagements, cash may not be appropriate and payroll options should be discussed (28). Employers must issue a T4 for any earnings over $500 per calendar year (23) and should ensure that peer workers are aware of requirements to declare their earnings as income (1). To prevent delays and ensure payment is processed promptly, organizations should set up a streamlined process with their finance department at the beginning of any peer engagement (28).

Disability and Income Assistance

Employers should carefully consider how peer workers receiving disability or income assistance may be impacted by different types of payment and earning limits to ensure they are not penalized (1). The BCCDC recommends discussing earnings exemptions and potential implications of paid work with peers receiving disability or income assistance; however, not all peers are receiving assistance, and many may already be informed about their earnings exemptions, so employers are advised to approach the discussion without assumptions. Such a discussion between a peer and their employer before their job starts enables them to make informed decisions on how best to proceed based on the impacts the job could have on their earnings. Under the Employment and Assistance for Persons with Disabilities Regulation in BC, some payments made for the purpose of supporting a recipient with a mental health disorder to participate in a volunteer or rehabilitation program may be exempt from income calculations for determining benefits assistance entitlements (34). Employers should stay up-to-date and informed on the regulations set forth by the Ministry of Social Development and Poverty Reduction to determine whether peer positions at their organization can qualify for earnings exemptions (28), and how these exemptions apply to people receiving federal versus provincial income assistance (31). Honorariums that are processed and coded by the finance department as gifts or expenses may also qualify for exemption (28). Lastly, employers should be mindful of the reporting requirements associated with government assistance programs and keep receipts for peers who need or would like them for their records (21, 28).

Communication on Compensation

A number of reports stress the importance of being upfront and clear about compensation at the outset (23, 28) by including the wage range on the initial job description (40) and discussing how additional expenses will be covered, when payment will be issued, preferred method of payment, and possible implications for disability or income assistance if applicable (23, 28).

Funding for Peer-led Groups

Many peer groups experience significant challenges in obtaining adequate funding and resources to support their work. Peer-run organizations often have the hardest time accessing this funding (46), which presents a major barrier to their long-term sustainability and stability, and limits the advocacy work they can do. To better support their efforts, governments and donors can invest in peer-led initiatives by offering greater financial support to peer groups (9).

Organizational and Work Supports

People with lived and living experience often face health and social inequities and discrimination (23, 30, 40). In addition to these societal stressors, crisis response can be challenging (31) and studies have found that peer workers are prone to high rates of vicarious trauma and burnout from their jobs (13). Despite these issues, peer workers often do not receive the same level of workplace supports and accommodations as their non-peer colleagues (8). Peer workers experience multiple forms of exclusion such as limited access to workplace infrastructure, supports and resources. Scanlan et al.'s 2020 survey findings suggest that a lack of access to resources and supports may demonstrate a devaluing of the professional expertise and contributions of peer workers at their workplaces (43). Much of the literature on best practices for peer employment stresses the importance of providing or improving access to a range of organizational supports in order to improve the health and wellbeing of peers in the workplace (23, 29, 30).

An area where lack of organizational supports is often evident is orientation upon hiring. Peer workers are often not given the same quality of orientation as their non-peer colleagues (40). A Toolkit for Co-production identifies a need for a formal job orientation and checklist that equips peer workers with the information and resources they need to address scenarios they may come across on the job. Such procedures and policies need to be tailored to the workplace and address the specific needs of peer workers, especially those who use substances (7).

Benefits and Accommodations

To promote wellbeing and prevent burnout among peer workers, it is imperative that organizations offer access to benefits and accommodations wherever possible (1). Upon hiring, employers should discuss accommodations with peer workers to determine what adjustments may be required (1). In one survey of consumer worker experiences of the workplace, Edan et al. found that over half of the participants surveyed reported having conversations with their organization's leadership about work accommodations and most indicated that they received a supportive response (41). Workplace policies such as paid sick leave can be especially helpful for peers who may need to take time off if they are experiencing challenges and need to focus on their health (29); however, employers need to consider and address the potential barriers that may hinder peer workers from utilising such policies. A study found that peers refrained from using paid sick leave or requesting accommodations due to fear of stigma and judgement and concerns over job and income security (30). Byrne et al. found that while there are concerns that peer workers will often require more accommodations, often none are needed when workplaces are adaptable and offer appropriate supports (14). Additionally, benefits such as extended health coverage and counselling, and policies that support flexibility, are important to enable peers to prioritize self-care and access

the resources and services they need to support their health and wellness (21). Access is often restricted due to the non-standard work arrangements that are common among peer positions (21), which highlights the importance of establishing formal employment relationships with peers whenever possible.

System Navigation

The inequities that some PWLLE face outside of the workplace such as unstable housing, poor living conditions, poverty and the criminalization of drug use are significant stressors that can impact their mental health and productivity (23, 40). Peers often experience challenges navigating health and social systems and face barriers to accessing supports (31, 40). In a study by the Peer2Peer Research Team, peer workers proposed a systems navigator position within organizations to address this issue. The navigator could support peers to access resources by making referrals and acting as an advocate once contact with service agencies and providers is initiated (40). Organizations could similarly create and circulate a list and map of community resources for peer workers to provide them with more information on the different supports available to them (23).

Intrinsic Motivation

Peers are often drawn to their work out of an intrinsic desire to improve their wellbeing and help others going through similar experiences. In Austin et al.'s qualitative study, they found that personal benefits attributed to peer employment were capacity-building, sharing expertise, relationship- and trust-building and destigmatizing substance use. These allowed peers to build on their skillset and expand their knowledge personally and professionally (17). Scanlan et al. reported that peers who are employed in community-based organizations reported being drawn to their role because of the complex nature of the work and the possibility of professional advancement; whereas peers in governmental positions were more attracted to the intrinsic rewards of the work (43). To reinforce these intrinsic rewards, organizations can highlight the positive impacts that peers are making in their communities and ensure their working conditions are conducive to supporting wellbeing (37). Employers can also encourage peers to reflect on and identify the aspects of their work that are the most meaningful, rewarding, and interesting to them and support them in pursuing these passions within their roles (7).

Self-Care and Wellbeing

The ability to set healthy boundaries, practice self-care and cope with stress are imperative for peer workers to be able to maintain their wellness and preserve their ability to support others without experiencing burnout (16). Despite their necessity, however, difficulties maintaining boundaries and practicing self-care are commonly reported by many peer workers (16, 31). Supervisors can help set a positive example for the rest of their team by teaching and modeling healthy boundaries (23). To promote better self-care, Greer et al. recommends that supervisors arrange regular self-care check-ins, which can occur within group or one-on-one meetings (23). Employers can ensure that staff take sufficient breaks during work and are entitled to vacation time. Organizations can arrange activities to promote stress reduction and healthy coping strategies such as team retreats, staff outings and stress management workshops (15).

Debriefing

Debriefing is another useful practice identified within the literature that can help peers deal with the challenges of their work (31). Scheduling regular debriefing meetings provides an opportunity for peers to discuss challenging situations with clients and work through any trauma triggers and difficult emotions that may arise (30). Debriefing can also help to foster interpersonal support among staff as they are encouraged to share their challenges and provide mutual support to each other (15, 31).

Peer Networks and Mentorship

Several reports highlight the importance of creating opportunities for peer-to-peer support, mentorship and networking (12, 23, 24, 26, 30). This is especially important for peers working with non-peer colleagues in interdisciplinary teams, as they often find connecting with other peers more difficult (31). Research has shown that when only one peer was employed at a worksite they experienced feelings of exclusion, rejection and alienation (45). Since peers make up a small percentage of the workforce, practices of isolation can become entrenched and lead to a lack of support and connection that may negatively impact peer worker self-worth and prevent meaningful participation (43). Peer-to-peer support and mentorship often occurs naturally and informally within workplaces, but organizations can intentionally create and support opportunities for this to happen more consistently (30). One way to do this is to employ a peer mentor that has experience working within the system to offer guidance to new peer workers on how to navigate the work environment and advocate for their inclusion in decision-making (23). Similarly, organizations can employ a peer support worker to provide social and emotional support to other peer workers and act as a liaison between peers and non-peer staff (30, 40). Peer-to-peer support can also be fostered through scheduling peer-only meetings, which provide a safe space for peer workers to check in with each other, talk privately, debrief issues in the workplace, and share mutual support and encouragement (26). Peer networks and communities of practice are another way to scale up peer-only meetings to extend beyond teams and even organizations for the purposes of maintaining health and wellness, sharing knowledge, transferring skills, and promoting best practices (12, 22, 24).

Unionizing

In a 2018 study, a local union was suggested by a number of BC peer workers to be a promising way to fight for improved working conditions and collectively resist inequitable employment practices (21). The potential benefits of a peer workers union are empowerment and equity, protection of workers' rights, better working conditions, and advancement of the workforce through increased recognition of its value and legitimacy (21). In their qualitative survey on the employment impacts on people who use drugs, Boyd et al. identify collective organizing and the unionization of harm reduction workers as a way to dismantle hierarchical workplaces and structures and move towards more equitable workplaces that ensure workers' rights (17).

Guidelines and Policies

Almeida et al. found that peer-led organizations were more comfortable hiring people with substance use disorders who were at risk of reoccurrence. These groups recognized that

employment was a key factor to help people in their recovery and offered positions with reduced responsibilities and hours to encourage showing up to work (33). The practice or policy of requiring abstinence or conducting drug testing to determine whether a peer worker has used substances is problematic and serves to single out employees who use substances (15, 40). Some employers even bar peer workers from accessing substance use services (e.g., safe injection sites) at their organization (17). These vital services should be accessible to all and peers should not have to hide their substance use due to fear of discrimination. Instead of requiring abstinence, Balian and White recommend that management focus on "fitness for duty," which is an assessment of whether an employee's behaviour is inappropriate, disruptive or prevents them from being able to perform their job. The caveat is that management should be understanding and accepting of physical reactions that people who use substances may experience that are outside of their control but do not interfere with their ability to complete their job duties. Organizations can support peers who use drugs by accommodating time off from work if they are going through withdrawal or are enrolling in a drug treatment program (15).

A lack of peer employment policies and guidelines was identified in the literature as a barrier to the advancement of the peer workforce (23). In the 2016 "Making the Case for Peer Support" report, the Mental Health Commission of Canada recommended the creation of national guidelines for clearly defining the peer support role, establishing avenues for funding and supporting the development of the profession (52). Guidelines and standards of practice are believed to be a way to build credibility for the essential role that peer workers play in the mental health system (12).

WHAT ABOUT INTERDISCIPLINARY TEAMS?

Many peer workers view the integration of peer work within the mainstream mental health system positively, believing it has the potential to lead to better employment opportunities and greater recognition of the profession. It's important, however, to note that some peer workers fear that further integration threatens the authenticity of peer support since it leads to assimilation with the traditional medical model, which focuses primarily on illness and medication (16, 46). The incorporation of peer work into hierarchical clinical policies and practices is seen by some to be at odds with its core value of mutual support (46). These concerns highlight the importance of ensuring that peer work is integrated into organizations in a considerate way that preserves its authenticity.

Equal Participation

A key barrier to the integration of peers within interdisciplinary teams is inequitable power dynamics between peers and their non-peer colleagues (23, 30). These imbalances are fueled by the health, social and economic inequities that often position PWLLE with less power and resources in society (23). To address these imbalances, many organizations stress the importance of promoting and fostering equal participation. In practice, this involves valuing a range of skills and experiences (24), giving people the means to take on different tasks (26), providing access to an equipped workspace (22), matching project activities to the skills and responsibilities of each person, acknowledging everyone's contributions as crucial to success, and setting expectations of mutuality where all staff are expected to ask for and offer help to each other (24). It also requires including PWLLE from start to finish (26) in the development, delivery, evaluation, and direction of projects and services (7, 24). To create the conditions for equal participation, power needs to be shared at decision-making tables (23, 27). Actions that can support this include developing the meeting agenda together (23), ensuring peers have access to all the information needed to participate fully (26), making space for everyone to share their ideas (7, 26), giving the same consideration to the opinions of peers and non-peer staff (7, 24), and recognizing the authority of lived and living experience (27).

Safe and Inclusive Work Environments

It is vitally important for employers to create a safe and inclusive work environment to support the successful integration of peers into interdisciplinary teams. One way to achieve this is by employing more than one peer within a team (18) and inviting more than one peer to participate in meetings and committees (22). Multiple peer perspectives not only give a stronger and more diverse voice to PWLLE, but also create conditions for peers to support each other and feel more comfortable since being alone at a decision-making table can be an intimidating experience (22, 23). The practice of setting ground rules and group agreements for working together as a team can create safety for peers to ask questions and request clarification if any unfamiliar acronyms or terms are used (23).

Stigma within the workplace is another major barrier to creating safe and inclusive environments for peer workers (22, 29). To address this issue, staff need to be mindful of how the language they use can perpetuate or reduce stigma. The BCCDC released a guide on the use of non-stigmatizing

language that recommends using "people-first language" and refraining from using moralistic terms that have a negative connotation (e.g., "people who use substances" vs. "drug abusers") (53). In addition to promoting the use of non-stigmatizing language, organizations should also put in place policies to prevent and address violence and discrimination in the workplace (40). Prejudice and attitudes from non-peer mental health professionals were often cited as an ordinary part of peer work experiences (45). Ti et al. found that people who use drugs (PWUD) were especially hindered from engaging in policy and programming because of prejudicial attitudes (9). Due to the authenticity necessary for the peer role, peers often feel concerned that open knowledge of their challenges will feed into the beliefs that peers offer less credible perspectives and reinforce the discriminatory assumptions about their abilities that further their tokenization (44). Stigma is a "deeply discrediting" experience and creates many barriers for peer workers, especially for peers who also identify as PWUD (8).

Peer workers have reported experiences of bullying and harassment while at work. In one study by Edan et al., about half of the participants reported being bullied and verbally abused (50.3%) at their workplace, had experienced threats (41.5%), witnessed their non-peer colleagues speaking derisively about certain mental health diagnoses (53%) and felt their work conditions were markedly different than their non-peer colleagues (59.1%). These issues often resulted in shorter tenures for peer workers because the workplace felt unsafe (41). Edan et al.'s survey further revealed that 60% of their participants felt unable to leave workplaces where they experienced bullying and exclusion due to a lack of other job opportunities (41). Survey participants of one study also reported that while 64.5% of those victimized reported the victimization, almost half felt the response they received after reporting was poor and provided an insufficient remedy (41).

Mental health professionals are sometimes unable to see beyond peers as clients or patients and therefore have a lack of insight into how to interact with peers at a professional level (45), which can lead to overly personal questioning of peers and perceptions of harassment (45).

Systems for complaints and disclosing discrimination are currently ill-equipped for a peer workforce since there is limited understanding of the role of peers and their unique needs (41). These formal mechanisms for support as they currently stand have been reported to disrespect confidentiality and lead to threats and the dismissal of complaints as subjective experiences. Peer workers are left feeling disillusioned and distrustful of accessing these supports that are meant to protect them (41).

Relationships Between Peers and Non-Peer Staff

A number of studies found that peer workers that worked for governmental organizations experienced greater isolation than their colleagues employed at community-based organizations (45) and that a key factor necessary for the successful integration of peer positions is the relationships between peer and non-peer staff (18, 37). A study by Burr et al. found that the factors that were considered to be a strong foundation for peer inclusion were all relational, including face-to-face communication, openness, respect and "humane" contact (18).

Byrne et al.'s findings reinforce the notion that mental health professionals are often uncomfortable interacting with people with mental health issues including peers that they may work with (45). There persists a perception that peer workers are "patients" or "pseudo staff" which may weaken

interpersonal connection between non-peer and peer staff (43). Workplace cultures that are not strength-based or recovery-oriented tend to lead to increasing feelings of dissatisfaction and disconnection among peer workers (43). Participants of various studies have reported being extremely conscious of how they are viewed by their non-peer colleagues because of their disclosure of their mental health status (41). Raising concerns was also found to be more challenging for peer workers since they are fearful their behaviours may be labelled as emotional or triggered due to personal traumas or histories and not seen as real challenges that arose during the course of their work (41).

To help foster relationship-building and promote better team cohesion, the Ontario HIV Treatment Network recommends organizing social activities for peers and non-peer colleagues to get to know each other better on a personal level (37). The recommendation aims to address common experiences of exclusion such as not being invited to social functions, team meetings and activities (41). Supervisors can support integration by helping to mediate conversations between peer workers and other staff members (37). Additionally, peers, by the nature of their job, enter into workplaces having already disclosed their lived experience status. To break down barriers, reduce stigma, and build rapport and trust among peer and non-peer staff, Burr et al. encourages openness and self-disclosure about mental health challenges by non-peer staff (18). Employers should understand that trust and rapport take time to build (23) and offer encouragement and appreciation for the contributions and accomplishments of peer workers (26).

Workplace Training

Evidence suggests that one of the key strategies for improving the integration of peer workers is to provide workplace training to increase understanding among staff of the role of peers, the realities that PWLLE face, and how peer and non-peer staff can effectively work together (22, 26, 30, 33, 37). Non-peer staff are often reported to have a poor understanding of peer worker roles (16), with one study finding that peer workers were often mistaken to be junior clinicians or community health workers (33). Non-peer staff's lack of awareness of the unique and vital contributions peers make to the mental health system (16) causes major challenges for integration and can lead to the devaluing and tokenism of peers within the workplace (30, 37). Improved communication on roles, responsibilities, and values of peer work could alleviate concerns non-peer staff have raised about peers replacing other workers and deskilling the workforce (1). Albeit, Scanlan et al. found that peer work is more at risk of devaluation and undermining than most other professional roles (43).

Education for non-peer workers on the value of peer work and recovery-based treatment is essential; however, responsibility for providing this education should fall on organizational structures rather than on peer workers who may become ostracized as troublemakers (43). Other recommended areas of training for non-peer staff include cultural safety, trauma-informed practice, the history of drug policy, harm reduction principles and philosophy and peer engagement best practices (23). The provision of such training can reduce stigma and discrimination and promote better workplace integration (22, 29, 37).

Guidance and Supervision

Peer workers frequently report having challenges interacting with management due to either lack of supervision (16) or poor supervision (30). Research has found that one of the main predictors of job

satisfaction among peer workers is having rapport with supervisors (54) and many express a desire for more frequent contact, support and consultation (18, 30). To support integration, Balian and White highlight the importance of ongoing and consistent supervision (15). This may involve setting aside specific recurring times for one-on-one meetings with a supervisor or scheduling regular team meetings to offer time for reflection and guidance (26, 30).

The types and quality of feedback given to peer workers is also important, with Taylor Newberry Consulting indicating that some peers wish to have more positive feedback, rather than only negative, for reassurance that they are doing well at their jobs (30). Byrne et al. found that participants in their study reported that the most important elements of good supervision were open door policies, timely debriefing, receptivity to feedback and an in-depth knowledge of organizational policies and mental health (14). Staff mentorship is another strategy for supporting integration within a team (37); however, as Greer et al. outlines, conversations should be initiated at the beginning of a project or employment relationship to determine the expectations peer workers' have of their supervisors and other colleagues in terms of support, learning and leadership (23).

Managers' attitudes towards peer support are vital since they can uplift or undermine the work of peers. Buy-in from leadership is critical for enabling the full integration of peers into the workforce (35).

Accessibility

Employers are required to address barriers related to accessibility. For instance, materials that are designed for service providers may include specialized terminology and be difficult for some peer workers to understand, although this should not be assumed. To begin, employers can ask peers how they learn best and make efforts to accommodate different learning styles (23). Some strategies that Greer et al. suggests to increase understanding are defining acronyms, refraining from using technical language, and including clear visuals (23). Additionally, the provision of hard copies of materials in advance of a meeting gives participants time to review and reflect on the information and can be especially important for those who do not have access to a computer (23). Since some peers may not have easy access to the internet or a computer for checking e-mails, employers are advised to discuss communication preferences with peer workers ahead of time to determine the best method to keep in contact (23, 26). To improve accessibility within meetings, breaks should be included on the agenda (26), and alternative options for providing input should be offered to those who may not feel comfortable speaking up in front of large groups (e.g., providing cards for people to write down their ideas) (7).

CONCLUSION

Throughout the literature, there is an abiding commitment to meaningful partnership and empowerment, perhaps best captured by co-production. The practice of peers and non-peer staff designing, delivering and evaluating services together embodies all of the core values of peer employment, namely collaboration, relationship, social inclusion, capacity building, harm reduction and holistic recovery, self-determination and equity.

Unfortunately, the literature also indicates that current practices of peer employment across different sectors and settings falls far short of co-production. Many peer workers still experience barriers to participation such as insufficient wages, benefits and supports, stigma and discrimination, and devaluation of their skills and contributions. The silver lining is that what is documented can be addressed.

Many researchers, organizations, and peer-led groups have issued best practices on how to equitably employ peer workers. A central tenet is role clarity. Often peer workers apply for jobs, get hired into an organization, receive minimal orientation and find themselves adrift without adequate supervision or direction. The situation leads to mistrust with non-peer staff and can reinforce stigmatizing beliefs about peer workers' abilities. Some of the simple solutions identified are clear job descriptions, comprehensive orientation, ongoing training, and adequate compensation and benefits. Non-peer colleagues can also benefit from training on the contributions of peer workers and organizations should create space to build trusting relationships where equal participation is not only encouraged, but required. Such a requirement, however, depends on safe, inclusive work environments, where barriers are systemically removed through policy and practice interventions.

Peers are a growing workforce and constitute a burgeoning area of research. In acknowledgment of this, our literature review is not comprehensive but includes a representative selection of the literature from 2010 – 2021 that documents both the current and best practices for peer employment.

WORKS CITED

1. CMHA – BC Division Consumer Development Project. Peer support: Resource manual. BC Ministry of Health Services, Adult Mental Health Policy and Mental Health Plan Implementation Division.; 2001.

2. Tang P. A brief history of peer support: Origins [Internet]. Peers For Progress. n.d. [cited 2021 Jun 9]. Available from: http://peersforprogress.org/pfp_blog/a-brief-history-of-peer-support-origins/

3. Ingleby D. Critical Psychiatry the Politics of Mental Health. Pantheon; 1980.

4. Shalaby RAH, Agyapong VIO. Peer support in mental health: Literature review. JMIR Ment Health. 2020;7(6):e15572.

5. Chamberlin J. The Ex-Patients' Movement: Where We've Been and Where We're Going. J Mind Behav. 1990;11(3/4):323–36.

6. Enoch J, Chang J, Guarinieri M, Agliata J. Taking back what's ours! A documented history of the movement of people who use drugs [Internet]. International Network of People who use Drugs. 2020 [cited 2021 Jun 17]. Available from: https://www.inpud.net/en/taking-back-whats-ours-documented-history-movement-people-who-use-drugs

7. Mersey Care NHS Foundation. A toolkit for co-production [Internet]. Equil Equality in Learning; 2015. Available from: https://cesie.org/media/IO4-En-Toolkit.pdf

8. Greer AM. Work experiences and conditions among people who use drugs engaged In peer work: A critical examination of peer work in British Columbia, Canada. [PhD dissertation.]. University of British Columbia; 2019.

9. Ti L, Tzemis D, Buxton JA. Engaging people who use drugs in policy and program development: a review of the literature. Subst Abuse Treat Prev Policy. 2012;7(1):47–47.

10. Slay J, Stephens L. Co-production in mental health: a literature review [Internet]. London: new economics foundation; 2013 [cited 2021 Jun 17]. Available from: https://neweconomics.org/2013/11/co-production-mental-health

11. Moran GS, Russinova Z, Gidugu V, Gagne C. Challenges Experienced by Paid Peer Providers in Mental Health Recovery: A Qualitative Study. Community Ment Health J. 2013 Jun 1;49(3):281–91.

12. Sunderland K, Mishkin W, Peer Leadership Group. Guidelines for the practice and training of peer support [Internet]. Mental Health Commission of Canada; 2013. Available from: http://www.mentalhealthcommission.ca

13. Kent M. Developing a Strategy to Embed Peer Support into Mental Health Systems. Adm Policy Ment Health Ment Health Serv Res. 2018;46(3):271–6.

14. Byrne L, Roennfeldt H, O'Shea P, Macdonald F. Taking a Gamble for High Rewards? Management Perspectives on the Value of Mental Health Peer Workers. Int J Environ Res Public Health. 2018;15(4):746-.

15. Balian R, White C. Harm reduction at work: a guide for organizations employing people who use drugs [Internet]. The Open Society Foundation; 2010 [cited 2021 Jun 9]. Available from: https://www.opensocietyfoundations.org/publications/harm-reduction-work

16. Rebeiro Gruhl KL, LaCarte S, Calixte S. Authentic peer support work: challenges and opportunities for an evolving occupation. J Ment Health Abingdon Engl. 2016;25(1):78–86.

17. Austin T, Boyd J. Having a voice and saving lives: a qualitative survey on employment impacts of people with lived experience of drug use working in harm reduction. Harm Reduct J. 2021;18(1):1–1.

18. Burr C, Rother K, Elhilali L, Winter A, Weidling K, Kozel B, et al. Peer support in Switzerland – Results from the first national survey. Int J Ment Health Nurs. 2020;29(2):212–23.

19. Macdonald D. BC Campus peer training curriculum study: Quantitative research final report. Insights West; 2020.

20. Lapidos A, Jester J, Ortquist M, Werner P, Ruffolo MC, Smith M. Survey of peer support specialists: Professional activities, self-rated skills, job satisfaction, and financial wellbeing. Psychiatr Serv Wash DC. 2018 Dec 1;69(12):1264–7.

21. Greer A, Bungay V, Pauly B, Buxton J. 'Peer' work as precarious: A qualitative study of work conditions and experiences of people who use drugs engaged in harm reduction work. Int J Drug Policy. 2020 Nov 1;85:102922.

22. National Consumer Panel. Stigma, Discrimination, and PWLE Knowledge Discussion Report [Internet]. Mental Health Commission of Canada; 2011 [cited 2021 Jun 9]. Available from: https://www.mentalhealthcommission.ca/English/media/3088

23. Greer A, Amlani A, Buxton J, the PEEP team. Peer Engagement Best Practices: A guide for BC health authorities and other providers [Internet]. BC Centre for Disease Control; 2017. Available from: http://www.bccdc.ca/resource-gallery/Documents/PEEP%20Best%20Practice%20Guidelines.pdf

24. new economics foundation, Holy Cross Community Trust. Co-production Self-assessment Framework: A working reflection tool for practitioners [Internet]. n.d. [cited 2021 Jun 9]. Available from: https://www.ourvoicesa.org/project/co-production-self-assessment/

25. Rogers ES. Peer support services: state of the workforce-state of the field in the USA. Ment Health Soc Incl. 2017 Jan 1;21(3):168–75.

26. Baker D, Belle-Isle L, Crichlow F, de Kiewit A, Lacroix K, Murphy D, et al. Peerology: A guide by and for people who use drugs on how to get involved [Internet]. Canadian Aids Society; 2015

[cited 2021 Jun 18]. Available from: https://www.catie.ca/en/resources/peerology-guide-and-people-who-use-drugs-how-get-involved

27. Byrne L, Stratford A, Davidson L. The global need for lived experience leadership. Psychiatr Rehabil J. 2018;41(1):76–9.

28. Becu A, Allan L. Peer payment standards for short term engagement [Internet]. BC Centre for Disease Control; 2017. Available from: http://www.bccdc.ca/resource-gallery/Documents/Educational%20Materials/Epid/Other/peer_payment-guide_2018.pdf

29. Chapman SA, Blash LK, Mayer K, Spetz J. Emerging roles for peer providers in mental health and substance use disorders. Am J Prev Med. 2018 Jun;54(6 Suppl 3):S267–74.

30. Taylor Newberry Consulting. Investigating the state of peer support work in Ontario: Findings and implications [Internet]. Ontario Peer Development Initiative and Self-Help Alliance; 2014. Available from: https://www.opdi.org/de/cache/resources/1/rs_Investigating-the-State-of-Peer-Support-in-Ontario-FINAL-REPORT-Nov282014.pdf

31. Ranger C. Meaningful engagement, meaningful results: Engagement and consultation road map from the provincial peer-training project [Internet]. BCcampus; 2020 p. 79. Available from: https://bccampus.ca/wp-content/uploads/2020/07/BCcampus-Peer-Engagement-and-Consultation-Report-v2.0-CR.pdf

32. Chinman M, McInnes DK, Eisen S, Ellison M, Farkas M, Armstrong M, et al. Establishing a research agenda for understanding the role and impact of mental health peer specialists. Psychiatr Serv Wash DC. 2017 Sep 1;68(9):955–7.

33. Almeida M, Day A, Smith B, Bianco C, Fortuna K. Actionable Items to Address Challenges Incorporating Peer Support Specialists Within an Integrated Mental Health and Substance Use Disorder System: Co-Designed Qualitative Study. J Particip Med. 12(4):e17053-.

34. Vancouver Coastal Health. Handbook for Contractors with Lived Experience of Mental Illness/Substance Use and Their Supervisors. 2017.

35. Byrne L, Roennfeldt H, Wang Y, O'Shea P. 'You don't know what you don't know': The essential role of management exposure, understanding and commitment in peer workforce development. Int J Ment Health Nurs. 2019;28(2):572–81.

36. Daniels AS, Bergeson S, Myrick KJ. Defining peer roles and status among community health workers and peer support specialists in integrated systems of care. Psychiatr Serv. 2017 Dec 1;68(12):1296–8.

37. Rapid Response Service. How to support and facilitate peer engagement in service provision roles [Internet]. Ontario HIV Treatment Network; 2013. Available from: https://www.ohtn.on.ca/wp-content/uploads/2016/12/RR76.pdf

38. Walsh PE, McMillan SS, Stewart V, Wheeler AJ. Understanding paid peer support in mental health. Disabil Soc. 2018;33(4):579–97.

39. Moran GS. A recovery-oriented peer provider (ROPP) work-role model and prototype measure. Am J Psychiatr Rehabil. 2017;20(4):346–68.

40. The Peer2Peer Research Team. Best practice manual for supporting peers/experiential workers in overdose response settings [Internet]. 2020 [cited 2021 Jun 9]. Available from: https://towardtheheart.com/peer2peer-project

41. Edan V, Sellick K, Ainsworth S, Alvarez-Varquez S, Johnson B, Smale K, et al. Employed but not included: the case of consumer-workers in mental health care services. Int J Hum Resour Manag. 2021;1–30.

42. Macdonald D. BC Campus peer training curriculum study: Qualitative research final report. Insights West; 2020.

43. Scanlan JN, Still M, Radican J, Henkel D, Heffernan T, Farrugia P, et al. Workplace experiences of mental health consumer peer workers in New South Wales, Australia: a survey study exploring job satisfaction, burnout and turnover intention. BMC Psychiatry. 2020;20(1):270–270.

44. Tseris E. The Expansion of the Peer Adviser Workforce: Opportunities and Challenges for Social Work. Aust Soc Work. 2020;73(2):162–74.

45. Byrne L, Roper C, Happell B, Reid-Searl K. The stigma of identifying as having a lived experience runs before me: challenges for lived experience roles. J Ment Health Abingdon Engl. 2016 2019;28(3):260–6.

46. Jones N, Teague GB, Wolf J, Rosen C. Organizational Climate and Support Among Peer Specialists Working in Peer-Run, Hybrid and Conventional Mental Health Settings. Adm Policy Ment Health Ment Health Serv Res. 2019;47(1):150–67.

47. Peer Support Canada. Peer Support Certification [Internet]. n.d. [cited 2021 Jun 9]. Available from: https://peersupportcanada.ca/

48. BCcampus. Provincial peer training curriculum [Internet]. n.d. [cited 2021 Jun 9]. Available from: https://bccampus.ca/projects/provincial-peer-training-curriculum/

49. Mental Health America. National Certified Peer Specialist (NCPS) Certification- Get Certified! [Internet]. Mental Health America. n.d. [cited 2021 Jun 9]. Available from: https://www.mhanational.org/national-certified-peer-specialist-ncps-certification-get-certified

50. Vandewalle J, Debyser B, Beeckman D, Vandecasteele T, Hecke AV, Verhaeghe S. Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: A literature review. Int J Nurs Stud. 2016;60:234–50.

51. Erica Thomson, Angeza Mohammed, Manai Masud, Dionne Mcgrath, Sonya Ishiguro, Sherry Baidwan. Developing a Peer Engagement Strategy for Fraser Health Authority. 2019.

52. Cyr C, Mckee H, O'Hagen M, Priest R. Making the case for peer support: Report to the peer support project committee of the Mental Health Commission of Canada. [Internet]. Mental Health Commission of Canada; 2016. Available from: https://www.mentalhealthcommission.ca/English/document/445/making-case-peer-support

53. BC Centre for Disease Control. Respectful language and stigma regarding people who use substances [Internet]. 2017. Available from: http://www.bccdc.ca/about/news-stories/news-releases/2017/language-matters

54. Davis JK. Predictors of Job Satisfaction Among Peer Providers on Professional Treatment Teams in Community-Based Agencies. Psychiatr Serv. 2013 Feb 1;64(2):181–4.

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