



Breaking Ground: Peer Support for Congregate Living Settings

Habitat Services

May 2010



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Media and Publications inquiries, please contact us by phone at 416-972-1010 or by e-mail at contact@wellesleyinstitute.com.

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MEMBERS OF THE RESEARCH TEAM:

Fionna Blair, Community Based Researcher
Joyce Brown, Ontario Council of Alternative Businesses
Kristyn Dunnion, Habitat Services
Dawnmarie Harriott, Community Based Researcher
Phil Hozer, Community Based Researcher
Joanne Knutson, Habitat Services
Laura Lesser, Community Based Researcher
Peter Lye, Community Based Researcher
Becky McFarlane, Ontario Council of Alternative Businesses
Chris Persaud, Habitat Services
Victor Willis, Parkdale Activity Recreation Centre

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	3
INTRODUCTION AND BACKGROUND	5
RATIONALE FOR THE STUDY	6
RESEARCH DESIGN, METHODS, AND ETHICS	7
THE FINDINGS	8
PHASE ONE: THE FOCUS GROUPS	8
PHASE TWO: INTERVIEWS WITH INDIVIDUALS PROVIDING PEER SUPPORT	13
PHASE THREE: INTERVIEWS WITH AGENCY REPRESENTATIVES	19
DISCUSSION	24
RECOMMENDATIONS	28
APPENDIX I: LITERATURE REVIEW	31
APPENDIX II: FOCUS GROUP QUESTIONS	39
APPENDIX III: QUESTIONS FOR INDIVIDUAL INTERVIEWS WITH PEER SUPPORT WORKERS	40
APPENDIX IV: QUESTIONS FOR INTERVIEWS WITH AGENCY REPRESENTATIVES	41

EXECUTIVE SUMMARY

This community based research project began as a simple enquiry into the nature of peer delivered housing support, in the hopes of designing an ideal model for a supportive housing project which is currently under construction in Parkdale, Toronto. Edmond Place is the Parkdale Activity-Recreation Centre's prodigious enterprise which will provide 29 furnished units in a beautifully renovated historic building – the same neglected edifice that at one time housed more than 50 psychiatric survivors before it closed due to fire. Edmond Place will be funded and monitored by Habitat Services as the newest addition to its boarding home portfolio. The Edmond Place project galvanized community support; initially blocked by neighbours, the project now includes members of the drop in, the wider social services network, and local residents in its planning and design committees. It is only fitting that future supports for Edmond Place tenants be as invested in the community, and that the mechanism to devise said supports be transparent, collaborative, and accountable to the people who stand to benefit most – future tenants, staff, neighbours and like-minded community mental health organizations, who can all learn from PARC's momentous undertaking.

What was not anticipated when we commenced this work, was the magnitude of comprehensive, rich dialogue about the nature of peer support. Instrumental in illuminating this dialogue was the involvement of community based researchers in all aspects of the project. There were three phases of data collection. The first phase consisted of a series of six focus group discussions with current or former tenants living in Habitat funded boarding homes, which uncovered diverse and meaningful examples of how tenants support one another in boarding homes and a widespread interest in access to peer support. The second phase grew to include the views of an expanding list of peer support workers, who were interviewed by community researchers. Their insights and experiences working in the field dramatically shaped our recommendations. Agency representatives were interviewed in the third phase; much of what emerged here was consistent with feedback from peer workers, albeit from a different perspective. A review of the burgeoning literature produced by one of the community researchers exceeded our initial expectations in scope and length. As well, lively debate about the dangers of professionalizing peer work, the use of 'peer' in job titles, and potential pitfalls of working within a larger system that embraces a medical model of service delivery are included throughout the findings, and particularly in the Discussion section.

We did not come up with a definitive support model which can be applied to Edmond Place or to other housing projects; our findings and thus our recommendations are not prescriptive. Similarly, recovery-based philosophy can result in best practice for support service delivery yet we still cannot conjure up a 'recovery model', a fool-proof methodological outline to that end. It is precisely this type of linear thinking that has historically dominated the medical model approach to social problem solving. There is no formula that could contain and explain an essential and radical change in philosophy, in agency missions and in day-to-day practice. What we offer instead is a list of recommendations – some of which are based on broad social observations. Others are specific mechanisms that can be incorporated within agency structure,

particularly in Human Resources departments. It will be up to each agency/organization to read and think through these suggestions, and to discern how best to implement them into their particular workplaces.

To summarize the discoveries of most critical importance we assert:

- That radical attitudinal change must take place in social service agencies at all levels of the organizations, and in the training programs that educate people to work in service of the public, including those who work in mental health.
- That as people who are touched by mental health issues in our personal and professional lives, we must work to lobby governmental bodies to fund anti-stigma campaigns and to actively work to reduce discrimination against people who experience mental health issues and illnesses
- That agencies and organizations must make concerted efforts to employ compassionate, connected people from the communities they serve in order to ensure relevant programming and services are delivered respectfully to empowered communities
- That agencies should hire for multiple positions and include community members at all levels of the organization
- That hiring processes change to reflect this new mission. Personal lived experience and demonstrated networking and community building work (volunteer or paid) should be weighted equally with relevant training programs. This change in focus must be reflected throughout the process, including where jobs get posted, how they are described, required qualifications, interview questions and résumé vetting procedures, etcetera
- That the workplace be flexible to accommodate employee needs and provide sufficient training and orientation to new employees, including access to an external network of peer support if desired
- That all agency staff prioritize the mission to foster and sustain autonomous, supportive relationships amongst service users, thereby encouraging leadership roles, capacity building and community development where it is most needed

It is imperative as agency employees and community members that we insist peer work be comprised of meaningful employment opportunities with flexibility and sustainability, and that diverse roles at all levels of agency work be accessible to people who are most invested in the communities served.

INTRODUCTION AND BACKGROUND

Parkdale Activity Recreation Centre (PARC) and Habitat Services formed a partnership resulting in a new housing project, Edmond Place. PARC is building the housing and will run the project. Habitat Services will refer eligible applicants and provide a subsidy for the ongoing operation of the housing. Habitat Services may also provide housing support to the tenants at Edmond Place. In preparation for this project, Habitat Services, PARC and the Ontario Council of Alternative Businesses conducted community based research to consider the support needs of tenants and the employment of consumer/survivors in a housing support role.

HABITAT SERVICES: Habitat Services is a non-profit community mental health agency funded by the Toronto Central Local Health Integration Network (LHIN). Habitat administers a housing subsidy program funded by the Ministry of Health and Long Term Care and the City of Toronto. Habitat enters into service contracts with selected private and non-profit boarding home and rooming house owners in the City of Toronto. The contracts describe the physical and personal care standards that must be maintained within each home. In exchange, Habitat Services pays the owner a specified per diem and monitors the provision of services to tenants. Currently, Habitat Services has contractual agreements with 41 for-profit boarding homes, 4 non-profit boarding homes and 2 shared apartments for a total of 870 tenants.

Complementing the contract monitoring function, Habitat and COTA Health provide on-site housing support services to tenants individually and to the community of tenants living in each home, to promote their housing stability and to support their recovery.

Habitat tenants are adults living with serious mental health issues, the majority of whom subsist on income supports from Ontario Works and the Ontario Disability Support Program, which are paid at lower rates to individuals who reside in boarding homes. Most tenants have been referred to Habitat Services directly from hospitals or shelters. Many face barriers which preclude their gaining access to or maintaining other forms of housing. Habitat funded housing provides a much-needed resource and contributes to the housing stability of consumers/survivors, but the consensus in the community health sector is that custodial forms of housing do not reflect best practices, particularly when unrelated adults are expected to share bedrooms.

Since the enhancement of recovery-oriented support to tenants was identified as a central strategic goal in 2004, Habitat Services has made efforts to integrate recovery oriented approaches into its work. While additional funding for the boarding homes would allow the agency to require and secure housing more conducive to recovery, this funding has not been forthcoming. Thus, the agency is pursuing creative ways of implementing recovery approaches from a limited resource base, within environments that present challenges and constraints. In this context, this research project represents a key agency initiative.

PARKDALE ACTIVITY-RECREATION CENTRE (PARC): The PARC drop-in community centre began on March 17, 1980 with a group of community volunteers who understood that there were a large number of adults living in rooming houses & boarding homes in the Parkdale area after the local mental health centres began to de-institutionalize long term psychiatric patients.

Most of these adults had little income, few family contacts and no place to go during the day. PARC hires from the membership, creates employment initiatives, develops new services, demands that people with mental health histories be treated with dignity and respect, and has worked for the improvement of the quality of life of all psychiatric survivors and marginalized persons.

PARC is developing new housing, Edmond Place, at 194 Dowling/1495 Queen Street where they will implement a new consumer driven approach to managing this form of accommodations. PARC's consumer driven Ambassador program has done a remarkable job of including the local community and informing them about the project. Edmond Place will host the implementation of a consumer/survivor driven boarding model informed by this research project.

THE ONTARIO COUNCIL OF ALTERNATIVE BUSINESSES (OCAB): The Ontario Council of Alternative Businesses (OCAB) is a consumer/survivor run provincial umbrella organization that develops and supports paid work opportunities for psychiatric survivors through several small non-profit businesses, including The Raging Spoon Catering Company, Parkdale Green Thumb Enterprises, and Out of This World Café. Their mandate is to develop survivor driven businesses that promote recovery, inclusion, economic gain, and training in marketable job skills. As research has indicated, employment opportunities are critical to the recovery pathway for consumer/survivors and lead to an increased stability and a reduced reliance on traditional mental health services. OCAB currently provides employment to over 120 psychiatric consumer/survivors within supportive and inclusive work place environments. OCAB brought its extensive experience with consumer/survivor employment, as well as its research expertise to the research project.

RATIONALE FOR THE STUDY

In 2007, the Ontario Council of Alternative Businesses conducted a community-based research project with funding from the Wellesley Institute and support from Habitat Services. Five tenants/former tenants were trained as community based researchers to conduct focus groups with Habitat tenants on issues relating to employment and barriers to employment. Participants suggested that improved education for employers about mental health and poverty and an improvement to current training opportunities and support programs would help reduce barriers to employment. The final report indicates that "there was a strong sentiment among participants that their life experience would make them good candidates for jobs in the social service sector if they were able to access more training in this field."

Edmond Place, PARC's housing project will be an important and innovative addition to the Habitat housing portfolio. Edmond Place, as a consumer/survivor driven housing model, represents an alternative to the traditional boarding home. In preparation for this initiative, Habitat Services, PARC and OCAB set out to build understanding of peer support and peer support models. In addition to facilitating the implementation of a pilot of a consumer run boarding home at Edmond Place, the partners also sought ways to promote peer support in boarding homes currently in the Habitat housing portfolio.

The case for peer support is clear. Nelson (2004) found that after 18 months of participation in peer support groups, members experienced fewer hospitalizations, fewer visits to emergency rooms, had more stable housing, were experiencing fewer symptoms and reported more friendships. Trainor J., et al. (1997) found that the use of mental health services dropped and social and community supports increased for individuals with peer support. The “Kirby Report” indicated that 41% of respondents participating in their e-consultation stated that their experience with service providers was negative. The authors suggest that self help groups of peers support individuals to speak out about their views. Ultimately, the report indicates that

“While acknowledging that professional help is valuable, people and families living with mental illness are turning more and more to self-help and peer support as a substitute for, or as an adjunct to, hospital and community and professional services.” (Kirby & Keon, 2006)

Within the continuum of supportive housing for individuals with serious mental health issues, boarding home tenants are particularly disadvantaged by income, lack of privacy, few opportunities to exercise autonomy, and social exclusion. Furthermore, many boarding home tenants have few professional and personal supports, having become disconnected from formal mental health services as well as family and community. Providing peer support is a strategy to address health disparities and improve the quality of life of boarding home tenants in a way that promotes empowerment and provides hope for recovery.

RESEARCH DESIGN, METHODS, AND ETHICS

Participatory research methods were critical to the success of this project. As we investigated the unique role that peers can play in recovery oriented approaches to supporting consumer/survivors, it was obvious that consumers/survivors should have meaningful participation in all aspects of the research. Not only were they consulted as key informants, they were also involved as community based researchers (building on the success of the OCAB initiative in which four Habitat tenants/former tenants were trained and conducted focus groups). This was an important principle given the research topic, and is also supported by evidence that consumer/survivors feel safer speaking with a peer researcher (Consumer/Survivor Initiatives: Impact, Outcomes & Effectiveness).

The community based researchers brought an impressive combination of expertise and experience to the project. Each of the community based researchers has a unique connection to the consumer-survivor community, and each has a particular lived experience and skill set that relates to different aspects of the community research. They were actively involved in the development of the research questions and tools, in facilitating focus groups and individual interviews, conducting the literature review, analyzing the research findings and developing recommendations. The Community Based Research Institute indicated that the strong participation of peers in our research team allowed them to waive the requirement for a peer reviewer on the ethics review board that assessed our submission.

The project included three phases of data collection. The first phase consisted of a series of 6 focus group discussions with current or former tenants living in Habitat funded boarding homes. The second phase consisted of one on one interviews with individuals providing “peer support” in the City of Toronto. Phase three was comprised of one on one interviews with representatives of a variety of Toronto based agencies and organizations that employ peer workers.

An ethics review of the research project was conducted by the Vancouver-based Community Based Research Institute’s (CBRI) Research Ethics Board (REB), as mandated by the Wellesley Institute. The REB provided insightful feedback on our research design and tools that helped us refine and strengthen the project. They also contributed to our understanding of current approaches to ethics in community based research.

THE FINDINGS

PHASE ONE: THE FOCUS GROUPS

The first phase of research was a series of six focus group discussions with current or former tenants living in Habitat funded boarding homes. Focus group participants were recruited through a variety of means. Flyers were posted in the boarding homes, at PARC’s Drop In, and distributed to Habitat’s tenant committee; people also learned of the focus groups by word of mouth.

The focus groups were held in six different locations across the city with an average of eight participants per group. Most but not all participants were currently living in Habitat funded homes. As a result, when participants were asked to contextualize their answers in their *current* housing, not all were commenting specifically on Habitat boarding homes.

Five of the focus groups were conducted in the following manner: a community based researcher fulfilled the role of lead facilitator, another community based researcher recorded responses on flip chart paper, an agency staff member or community based researcher served as note taker. The sixth focus group was held in a boarding home in which the tenants speak Vietnamese or Cantonese. The lead facilitator role was fulfilled by two agency staff (one of whom was Vietnamese-speaking) who had not previously been involved in the research. They recruited two peers (i.e. a tenant and a former tenant) with interpretation skills in Vietnamese and Cantonese to assist in facilitation. Group discussions were held simultaneously in Vietnamese and Cantonese, with feedback shared between the groups. The collaboration of staff and peers in the facilitation of this final focus group allowed us to gather the feedback of ten tenants who had not volunteered for the focus groups held in the community. While the ability to use their first language undoubtedly contributed to their decision to participate, they may also have felt more comfortable participating in a group conducted within their immediate tenant community, with facilitators with whom they were familiar.

At the outset of each focus group, facilitators obtained informed consent by providing relevant information about the research, confidentiality, and the focus group format; facilitators ensured that participants wished to continue with the process. At the conclusion of the focus groups, participants were given an honorarium of \$20.00 to acknowledge their time and effort. Participants who travelled to focus groups were also given T.T.C. tokens. Beverages and light snacks were provided for each group.

In attempting to define “peer support”, group participants discussed what they thought the term “peer” meant. Some said it meant having the same experience or sharing common experiences. Others situated peers in a group or community, and saw them coming together to talk about a common problem or a common issue (e.g. ODSP). Many referred to a foundation of trust, understanding, and/or equality in the peer relationship. *“No matter what the issue is, it is sharing a bond, they can understand and they know what it’s like.”* (focus group participant) Peer support was also described as “mutual support and advocacy”; tenant groups or councils where members have a voice; having a support system; and something that results in an improved quality of life. Some participants interpreted peer support as friendship. One group also associated peer support with cross-cultural connections.

After this discussion, each focus group facilitator presented our working definition for the purpose of the study: ***someone with lived experience who is working in a support role in a housing setting.***

Supports that currently exist in their housing:

- COTA Health or Habitat Housing Support staff who visit the homes a number of times a week, and provide group activities and outings with tenant input, as well as practical assistance (e.g. help with income supports, I.D., bed bug prevention)
- Other Habitat staff (who monitor the standards in the housing, provide mediation)
- Boarding home staff, who cook, clean and at times provide some other types of support
- Other visiting workers, depending on individual tenant supports (e.g. ACTT, personal support workers)
- Support from other tenants

While many participants acknowledged or expressed confidence in Habitat Services and COTA Health’s services, not all participants saw them as effective in resolving issues with the quality of their housing.

Mutual Tenant Support:

Participants described a broad spectrum of activities including concrete tasks such as helping to find housing, to move, accompaniment to appointments, language interpretation, doing personal chores, helping when someone is sick or injured. Sharing resources and information and helping others connect to services was another distinct area of mutual support. They described emotional support provided in the form of encouragement, listening, making offers of help, and friendship. Participants also described group social activity and encouragement to

exercise as support. Focus group discussions uncovered diverse and meaningful examples of how tenants build relationships and trust in supporting one another while living in boarding homes.

“The good thing about living in a boarding home is everyone looks out for everyone else. It’s like family. You develop a sense of community within the house. You end up caring for the people you live with and you feel their pain. A girl in the house, who had a stroke, is afraid to walk outside in the night by herself, so if she needs to do something we walk with her.” (focus group participant)

Participants reflected on the growth, healing, and recovery that can take place among peers. *“I want to become more self-reliant. Other tenants help me feel that way.”*

Barriers to helping others:

Participants identified poverty as a main barrier. One tenant said, *“It’s hard on \$110.00 a month, I would like to help financially, but it’s really hard.”* Lack of access to public transportation was also mentioned. Other challenges include fear, language skill limitations, being told to stay out of others’ business (e.g. by the landlord), a limitation in health status (both mentally and physically), and the recognition that you can help, but that “people also need to help themselves”.

“It feels great to offer someone a coffee, but some of us can’t afford this.” Focus group participant.

Participants would like access to:

- more support/advocacy in dealing with landlords
- more support to get entitled housing services
- relaxation and exercise programs (e.g. Tai Chi, walking, badminton)
- enhanced security or tenant watch program
- computer and internet
- employment assistance
- accompaniment to appointments
- the option to cook, shop and do laundry
- emotional support from someone when they need it
- mediation for conflicts that arise (perhaps a peer leader)
- more general on-site support

Jobs currently being done by tenants include:

- maintenance and repairs
- house keeping
- garbage/recycling duties
- kitchen/dining room assistance

- gardening and grounds keeping

One participant commented that *“most work is unpaid or meagerly paid”*. Another said, *“not just doing the crap work would be good...”* In one instance, a participant indicated that the landlords were paying for a tenant who had previously worked as a chef to get an updated Food Handler’s Certificate, so that he could *“officially help in the kitchen.”*

“When living in a boarding home you gain and lose skills. I need help recapturing them.”
Focus group participant.

Jobs that could *also* be done by tenants/peers:

- resource person for other tenants
- accompany tenants to appointments
- menu planning
- bring meals to sick tenants
- provide emotional support
- mediation
- cook
- help others to find hobbies or volunteer work peer support work
- translation

“Being an old Union guy, I wouldn’t want to take any jobs away from the house staff.” Focus group participant.

A number of participants suggested sharing responsibilities within the tenant community with chores rotated or divided among tenants. Some envisioned this as an opportunity to have more choice, especially with respect to food. One participant suggested that tenants take turns cooking once a week with the help of a peer *“so that they could learn.”* Participants in one group expressed concern about taking work away from the boarding home staff and were reassured to learn that suggestions were likely to be used in a new housing model, rather than in re-structuring their current home.

Benefits of having a peer provide support in their home

- **Connection and understanding**

One participant commented *“staff sometimes think ‘Oh they are retarded, they’re mental’*, adding that staff sometimes yell at people who are really sick. In a similar vein, *“When you have a mental illness, you’re really going out on a limb to talk to someone else about stuff. You don’t want to be judged.”* Another participant remarked, *“You can celebrate the way you live with peers.”* Participants saw a peer in a support role as someone who would better understand their situation, and whom they could trust.

- **Improved health and well-being**

Multiple participants indicated that having a peer provide support in their home would decrease their use of mental health services. One participant saw a benefit in seeing *“someone else with mental health issues in a positive role, like a mentor or model”*, as *“someone that*

consumed it and survived it.” Others thought peer support would promote a healthy, mutually supportive setting.

- **Additional services and support**

Help to develop skills, accompaniment to appointments, financial advocacy, mediation with the landlord, and more emotional support were repeatedly mentioned by participants. They generally saw peer support as something that would enhance their living environment in tangible ways. A peer support worker leads by example and can inspire tenants towards greater independence. *“Someone who has gotten out of [this] housing - they would be the ones to come back and share their stories; they got apartments, took courses, etc.”*

Potential challenges to having a peer provide support in their home

- **Access to training/support for the peer support worker**

Participants underlined the need for the peer to have adequate support and training, presumably from colleagues, a supervisor, and/or peers, to do their work. Some participants wondered if aspects of the interpersonal dynamic between staff and tenants would be reproduced in the peer/tenant relationship. A number of participants acknowledged power issues, suggesting that the peer would be *“perceived to have power”*, or to be *“on the staff side”*, while another expressed concern that the landlord and boarding home staff would not take the peer worker seriously. Participants acknowledged that peers would not always agree, that conflict of opinion on situations was natural, and that the peer would have to accept tenant autonomy.

- **Logistical issues**

Scheduling, availability, physical layout of home not being conducive to privacy, are examples of perceived challenges. The detrimental impact that extra *paid* work could have on a tenant’s income, presuming the tenant received disability income, was noted.

Skills and qualities that peer support workers should have:

empathy and understanding, good communication skills (multiple languages), advocacy skills, life experience (including mental health and living in shared accommodation), resourcefulness, respect and fairness, ability to help others towards greater independence, knowledgeable regarding services, confidentiality and knowing one’s limits. Participants expressed that it takes a certain kind of person to do peer support work. Recommendations for training included: CPR/First Aid, crisis intervention, leadership, mental health, communication skills, on-the-job and ongoing training, Gerstein Centre training (non-medical crisis intervention, Wellness Recovery Action Plan), and self-care to deal with job related stresses.

PHASE ONE CONCLUSION

When asked if they would be interested in having a peer support worker/program in their home, participants answered in the affirmative with one exception. The only tenant who clearly said no, cited

“I’ve been through the system and sometimes I get along with the psychiatrists and sometimes I have conflicts with them. Sometimes you gel and sometimes you don’t. Well, it would be the same thing with a peer worker, too.”
Focus group participant.

availability as a concern. Most participants believed that having a peer support worker/program in their home would result in more support and better security for tenants. Some contrasted the quality and type of support provided by a peer with the work of other staff. *“We sometimes need someone to be able to talk to, one-on-one, in order to feel emotionally better. Staff say: ‘you need more medication.’ In a group, when we talk about a common problem, we all feel better.”*

In hindsight, we note that the nature of our focus group questions may have narrowed participants’ thinking toward the current, traditional boarding home framework rather than imagining something new. Ultimately, the responses to our questions emphasize peer employment rather than more general “grassroots” peer support. Nevertheless, participants also explored aspects of informal mutual support that unfolds organically. This type of interaction is the foundation for building trust and relationships; we see it as being integral to

“The boarding home staff is not trained to deal with mental illness and they go overboard with incidents. A peer could help communicate.”

Focus group participant.

meaningful community development, and would hope to foster this culture of mutual aid in the boarding homes, as well as pursue employment options for peer support workers. Participants who currently experience mutual support with their housemates noted that paid work cannot replace the invaluable relationships between friends, peers, and neighbours; those relationships are often the very foundation of personal support and recovery, and help create meaning in their lives.

PHASE TWO: INTERVIEWS WITH INDIVIDUALS PROVIDING PEER SUPPORT

Phase two of the Breaking Ground research project involved one-on-one interviews with people currently working in Peer Support Worker positions in Toronto. Community researchers were asked for personal contacts in the field; we identified several relevant agency programs and tried to locate representative contacts from each one. Through grassroots connections and word-of mouth communication, we were able to shortlist almost thirty peer workers in the city. Some workers were not available to meet, some had left their positions, and others were simply too busy to commit to an interview. Interviewees were offered an honorarium of \$20.00 and the choice of time/place for the meeting. TTC tokens were offered if the individual was required to travel for the interview. If the interview subject was available to meet during work hours as part of workplace duties, we did not offer an honorarium.

A total of 20 individuals participated in this phase of the study; six identified as males and 14 identified as females. Almost half of the individuals said they were in the 45-54 year age range (45%). 25% were 60 years old or older. Two individuals identified Spanish as their first language – the rest spoke English (one person did not answer this question). 22.2% of interviewees speak a language other than English.

We interviewed peer workers from Houselink, CAMH, CMHA, the Krasman Centre, St. Jude's, the Gerstein Centre, Street Health, PARC, Toronto Western Hospital, and Toronto East General Hospital. Job titles included: Drop In Worker, Peer Recovery Facilitator (3), Breakfast Facilitator (2), Peer Support Worker (4), Supportive Housing Worker, Wellness Recovery Worker, Community Kitchen Facilitator, PARC Ambassador Program Coordinator, Peer Support and Harm Reduction worker, Consumer/Survivor Worker in Training. Half of the people who answered the question stated that they work full time (8). Seven work part time, and one chose "other".

Candidates defined "peer support" rather uniformly, stating that it involved identifying as having similar lived experiences. *"People with similar experiences helping each other in practical ways with life problems,"* said one. Another phrased it as *"Helping ... those in your community who have a similar life to yours."* Several individuals elaborated on the ideals or possible outcomes of this relationship, too. *"You help to navigate the system."* And, *"A peer worker listens to me if I need help and doesn't judge whether it's good, bad or ugly."*

Peer Worker duties and responsibilities include:

- Provide informal counselling and support
- Identify as consumer/survivor
- Facilitate peer groups
- Life skills mentoring
- Provide one-on-one support
- Build community contacts with non-clinical support groups
- Facilitate weekly in-patient groups
- Organize and participate in recreational activities
- Prepare breakfast, put out dishes etc, clean up afterwards
- Advocate for clients with team members (ACT)
- Court support
- Case Management
- Represent Landlord, mediate Landlord/tenant issues
- Referrals: housing, health, and addictions services
- Supervise other paid and unpaid staff
- Administration and reporting requirements
- Accompany in-patients off site for hair appointments, shopping etc
- Assist to operate the house
- Cook, laundry
- Input patient information on computers, read charts
- Orientation of new clients
- Coordinate Alumni meetings
- Public speaking
- Program development
- Statistics

82.4% of those who responded indicated there are other peer workers at their agency (14 of 17 responses). Most individuals declared they received support in their jobs from supervisors or managers. They also listed (in order of popular response) colleagues or other staff, peers, outside supports, and the clients themselves.

Supports clients are lacking:

- Not enough peer workers and not enough hours to meet clients' demands
- Specific supports for youth and also for the aging population
- Supports for specific cultural groups, multi-lingual services
- Supports for Lesbian-Gay-Bisexual-Transgender-Transsexual clients
- Immigration supports
- Support for people with mental health symptoms *and* addictions issues
- Access to supports on weekends/evenings
- Better meal programs
- More options for quiet recreation
- Safe venues for community building

“There is still a tendency to impose external forces towards creating change, rather than providing the space for internal healing and understanding to occur. It is difficult to create space to explore difficult feelings or take risks without being re-institutionalized. This is very important (for clients, but especially for peer workers) to be able to debrief after difficult sessions, just to talk and reflect on feelings/memories.”

Supports peer workers are lacking:

- Funding for full time positions with benefits
- Commitment to more than short term contracts
- Sense of connection to the rest of the organization
- Meaningful input to the program and to decision making
- Sense of partnership with other agency workers
- Opportunity to debrief with supervisors and other staff

“Having someone to confide in at work without having to worry about them taking notes or reporting to someone what I say or what I am thinking” would be appreciated. Another said *“There is still confusion within the organization about the benefits of the peer role – [it’s] easy to either be seen as a ‘former client’ or as a ‘pseudo’ clinician.”*

Strengths and assets peers bring to the job:

- Good communication, listening, and interpersonal skills
- Respectful, empathetic, courageous, non-judgemental
- Street cred
- Sensitivity to the issues surrounding mental health, addictions, and recovery
- Inside knowledge of the system
- Specialty knowledge/language due to having lived the experience

"I think one of my key strengths is a level of authenticity, of being able to listen and also to share my understandings about my own journey. I have also had experience of being on both sides of power dynamics so am able to often act as a bridge between other staff and clients."

"As a consumer/survivor I have known stigma, hospital stays, being devalued as a person and having [my] housing threatened. I know how to work above that to find solutions."

"The medical model takes up so much space as opposed to providing organic supports based on an individual's needs or desires. The Doctor sets the tone and parameters, [not] the client."
Peer worker interviews.

Rewards of providing peer support are two-fold. Many comment on vicarious rewards – feeling satisfied through helping others; they also report self-development or personal growth as a result of this type of work. People commented that they "liked" the work, and liked being a positive influence or a mentor to others in need. *"Being responsible can be overwhelming, but members are looking up to you."*

Challenges include:

1. Tension between the medical model and a recovery-based approach to delivering services
 - Peer workers note the medical model is not in tune with clients' experiences
 - Mental health stigma warps relationships that clinicians have with clients
 - Trying to get professionals to view clients as individual human beings rather than statistics
 - Trying to teach professionals what is meant by and needed for meaningful recovery
 - Communication barriers in a large institution (email/voicemail, access, timeliness of messages)
 - Translating client experiences into language the ACT team can understand without being fearful
 - Pressure to "report" on clients or their behaviour, required to divulge personal client information to supervisors in certain situations

"I have staff interacting with the patients a lot more, but they still wear gloves and bring towels to sit on the chairs; this makes the patients uncomfortable."

2. Human Resources issues
 - Not enough funding for full time, permanent Peer positions
 - Multiple visits, excessive travel, unknown work environments (personal safety)
 - Not enough time for administrative work requirements
 - Lack of resources: never enough services
 - Stressful working part time and being on ODSP

- Not being recognized as staff/leader

“As this is a relatively new role, there is also quite a bit of negotiating with staff, with management and with clients to really see where the role can help change the system.”

3. Challenges related to the actual work

- Rude or disgruntled clients
- Must sometimes collaborate with emergency personnel, including police
- Triggers regarding addictions
- Establishing healthy boundaries with clients/staff
- Outreach – getting people to WRAP programs, motivating clients in general
- Discrimination due to identifying as a “peer”

“Having a mental illness equates to being stupid, illiterate or criminal, and for whatever reason people believe that. You’re not considered credible. In a couple of past incidences, I didn’t have the training, didn’t know about the boundaries, or I wasn’t given the same information as the clinician.”

Peer Worker Training

- Conflict resolution
- Group Facilitation Skills
- Counselling skills
- Establishing healthy boundaries
- Diversity training
- CPR
- Suicide prevention
- Crisis Intervention
- Addictions Issues

Seven people recommended WRAP (Wellness Recovery Action Plan) training by name. Pathways to Recovery was mentioned, as was Shery Mead and Like Minds Education. More generally, people suggested training courses in a variety of areas. Some noted that the agency/employer should offer or pay for these opportunities. Life experience, familiarity with local resources, relief work and/or volunteer experience, as well as good organizational and interpersonal skills were all noted as very important to this line of work. One person noted that *“Non peer staff needs training more than the peers do,”* where stigma is concerned.

Self-disclosure to peers

Peer workers felt that identifying as a person with specific lived experiences should be a positive thing; it works to reduce stigma, improve possibilities for others, creates an atmosphere of trust, and it is a basic requirement for “peer” work. In some cases, individuals made amendments to their general support for self-disclosure, including outlining appropriate

contexts – that it should be confidential, and that other people (employers) should not disclose your status without your permission.

“This is a given with the nature of the job – our job titles disclose that we have experience with the mental health system. I accept that it is a component in who I am (but only that), and do not feel obligated to trot out ‘my story’ on demand. I do find that I will often talk about aspects of my recovery if it seems relevant in actual instances of peer work.”

Self-disclosure to other staff in the field

Although most peer workers felt this was also vital, many noted that stigma was a powerful barrier in their workplaces and in the larger work field. Fear of being reduced to “an illness”, of being perceived as a threat to the institution, of being demeaned by other workers was expressed. Issues of confidentiality and of personal choice in disclosing identity were important.

Personal challenges

Workers observed that the emotional cost of working in this field varied. Several noted the danger of becoming frustrated, or *“too invested emotionally in [other people’s] outcomes”*. Another said, *“Exhaustion! Sometimes when a member is in crisis they can suck the life out of you.”* One individual noted that dyslexia and an abbreviated education due to being “raised on the street” was a challenge, but that s/he was provided with a software program to assist in writing reports.

“There is a fine balance between being authentic in my connections with people and being too involved in their personal choices. I find it particularly daunting when I hear of people who haven’t been able to work through their demons, or when I am connecting with someone who triggers strong memories of my own darkest times. I am learning to pay attention to my own state of grounding and to acknowledge when I have been personally triggered – to allow myself the time and space to regain my grounding and to maintain my own personal boundaries and sense of self, without diminishing from their own story.”

Peer support in a housing setting

Benefits:

Peer workers imagined that having peer support in a housing setting would improve access to support and help to create a stable, calm home environment. Specifically:

- Easy access for residents
- Safe space
- Normalizes interaction: not a clinical culture (appointments)
- Develop peer skills in all tenants, positive role models
- Knowing one another better
- Welcome new tenants, orientation to home and neighbourhood
- Help to create a homey environment
- Assist with daily living routines
- Better social opportunities, harder to become isolated

- No travel costs for tenants

Challenges:

Half of the people interviewed declined to answer this question, and a couple of people stated there would be no challenges. Others noted:

- privacy for tenants who disclose information
- privacy for the peer worker
- boundaries

Live-in Support Workers:

When specifically asked about support workers living in the house versus support workers visiting the house, one half of the respondents strongly advocated for the latter. Almost all noted benefits for each arrangement, observing the advantages of access for tenants, regular daily contact, and the fact that the support worker would know the living conditions intimately. However, respondents also noted that constraints and/or demands on the worker would be difficult. *“When do you stop working?”*

Advice for agencies

Peer workers made suggestions to housing agencies that are trying to incorporate peer support.

- Equitable treatment of peers and non-peer staff including work conditions and training opportunities (liveable wage, reasonable hours)
- Allow peers to design and execute programs, include in decision making and training
- Create agency hiring policies to include people with lived experience
- Provide opportunities for peer workers to meet with peers from other agencies
- Know housing goals well (long/short term, transitional, recovery focused etc)
- Know potential employees very well (skills, abilities, character)
- Involve tenants in peer planning where possible
- Ensure the home is comfortable and safe for tenants and staff
- Provide contact information and referral source information to peer workers
- Have a bedbug protocol

PHASE TWO CONCLUSION

Material collected during peer worker interviews demonstrates that the people currently working in the field of peer support have an acute understanding of what is most and least useful to their clients, what is most challenging for their employers and colleagues, and the things that most need to change in order for peer work to flourish and be properly recognized in the field.

PHASE THREE: INTERVIEWS WITH AGENCY REPRESENTATIVES

Phase Three of the Breaking Ground research project solicited feedback on peer support from representatives of a variety of Toronto based agencies/organizations. Agency staff members of the Breaking Ground research team conducted structured in-person or telephone interviews

with people in managerial or coordinating positions within the following workplaces: Houselink Community Homes, the Canadian Mental Health Association (CMHA), Mainstay Housing, the Ontario Peer Development Initiative (OPDI), the Gerstein Centre, Sound Times, the Centre for Addiction and Mental Health (CAMH), Toronto Western Hospital's Assertive Community Treatment (ACT) team, and Compass (Toronto East General Hospital's ACT team). One agency representative submitted responses electronically. This phase of the research included housing, community mental health, and hospital-based services.

Each of these organizations employ individuals with lived experience of the mental health system and/or homelessness. With one exception¹, they employ individuals with lived experience in positions that provide support as a key part of their role. Almost half the organizations use the term "peer support" to describe what is provided by these staff, and reflect this in their job titles (e.g. "Peer Support Worker", "Peer Facilitator"). One respondent questioned the use of the term "peer" in relation to paid support work. She argues that an individual may have similar lived experience, but receiving pay creates a power dynamic. Therefore they are no longer peers, since peer "indicates association at the same level".

Several people said that consumer/survivors are fully integrated into the workplace in "mainstream positions," as one respondent phrased it. People with lived experience hold a variety of positions within their agency structures. One of these, The Gerstein Centre, also has an innovative training position for a psychiatric survivor, which is salaried. Other jobs held by and designated for individuals with lived experience within these agencies included Social Recreation Assistant, Wellness Recovery Worker, Community Support Counsellor, WRAP facilitators, and "Fresh" program staff who focus on wellness and fitness. Peers also work in a wide variety of programs including Streets to Homes, transitional housing, Mental Health and Justice, drop-ins, resource centres, drug treatment, and other clinical programs and services.

"Volunteering in peer work is risky, as it borders exploitation. A lot of people end up volunteering for much too long. When people enter the volunteer role, the main goal is employment. Most people want to do peer work, but there are not enough jobs so they end up in a volunteer role. Volunteering should be time limited."
Agency interviews

The number of positions designated for consumer/survivors within these agencies ranged from 1 (3 agencies) to 12 fulltime equivalent positions plus many casual part-time workers. For agencies in which consumer/survivors are fully integrated, the number is theoretically limitless. The agencies surveyed vary greatly in the total number of staff employed. 78% of the agencies interviewed offer full-time positions with salary and benefits, 55% offer part-time positions with hourly wages and 22% offer training/mentoring opportunities with honoraria. No agency reported strictly volunteer positions.

¹ OPDI does not provide direct service, but is developing training and certification on peer support core skills. It is required that *all staff* identify as consumer/survivors.

Recruitment for Peer Positions:

Most agencies advertise peer positions in the same way that they advertise for other positions - using multiple, public forums. Some highlighted the use of member mailings, on-site postings, websites (e.g. their own, Charity Village), the Consumer/Survivor Info Bulletin, OPDI's NewsToGo, ethno cultural newspapers, and other media which are free to the reader and do not require internet access (e.g. NOW magazine). Most respondents seemed to assume that the people who use or have used their services would see the postings in one or more of these forums and did not use other mechanisms.

One housing provider surveyed said that in the past they recruited a Peer Support Intern directly from their tenant population, but found that *"being a person's landlord and their employer creates some complexities."* This position has evolved into a Peer Support Worker position; the housing provider posts and hires externally. Another housing agency hires for fulltime permanent positions from within their tenant population, with the expectation that the tenant/staff will negotiate moving out of the housing after completing probation. The rationale is that 1) other staff would have access to the tenant's personal information, and 2) there would be a power difference between the employed tenant and other tenants, due to their paid staff position. The agency does not expect other staff who are not in support roles and/or who are only working part-time or casually to move out. Other agency representatives clearly stated that support workers should not live in the same home where they work because it would place unfair demands on them: *"Your home is your home. When you close your door, it should be over."* Eligible candidates for the Gerstein's paid training position must not have used their service for six months.

A number of people stressed that their job postings include equity statements, or include "lived experience" as a qualification or requirement of the job. One respondent advised that these criteria should not be linked to the medical model or illness. Another indicated that their agency has two designated positions that require lived experience, and also follows comprehensive equity hiring policies. The CAMH representative added that CAMH *"wanted peers who understand the impact of poverty"*.

Feedback Mechanisms and Support:

Supervisory structures and performance reviews for peer support workers and other staff with lived experience were generally the same as for other workers in these agencies. An exception was for the paid training position at the Gerstein Centre, where there are weekly supervision meetings. The training position assumes that the trainees have not been able to obtain employment due to barriers, and not everyone *that has potential* meets the criteria for regular employment at the Gerstein. Another exception is for the WRAP facilitators at the Gerstein who are evaluated by the WRAP participants.

One respondent suggested that peers need to be supported and know their job clearly - reviews should be directly linked to job descriptions, the employer should encourage questions if the peer is unsure about something in the role/job, and the employer should clarify as much as possible. Two respondents stressed the importance of giving the peer a thorough

orientation to their workplace. *“Peer workers don’t attend staff meetings, although this is changing, and some units are inviting the peer workers to participate. As the two groups get to know each other, it is getting better.”* While some respondents perceived that peers may require some additional support due to workplace barriers, there was an emphasis in the feedback on the manager’s responsibility to “honour the role”, have “sensitivity to consumer/survivor issues”, and promote peer integration.

Benefits to having peer workers

- **Breaks down stigma, stereotypes, and discrimination**

One person reported that as the number of employed consumer/survivors rise in their agency and the environment becomes safer, more staff “come out”.

- **Promotes recovery and a safe space**

Some respondents referred to the positive impact of “role modeling”. One commented that clients are “developing their own voices and becoming more confident” as a result of peer support. Peer workers readily develop trust and bring different approaches that service users can relate to. *“Peers make a huge impact on programs and service users since peers can walk on paths where other staff can’t, like when someone has a shared experience.”*

- **Results in more appropriate, responsive, person-centered services**

One person said the peer worker reminds agency staff to consult with clients directly, a common oversight. Another agency representative said peer support work *“connects us to other members in a way that traditional positions do not.”*

- **Better educated staff**

Respondents commented on how much their agencies learn from peers. For example: *“He’s been training us and makes us realize why we’re doing the work that we’re doing.”* Two respondents said that peer support workers have been educating their teams on medications and side effects. Part of the CAMH peer support job is to educate full-time staff on the social determinants of health and the impact of poverty.

- **A more complete picture and a more diverse agency**

“When we are facing a complex decision on a difficult issue we get ALL different perspectives, including those of people with lived experience...There is a value to having people on staff who are reflective of the people that use your service.”

- **Strengthens the consumer/survivor community**

Staff with lived experience help *“build a network of relationships that are supportive to others, (they are) hooked into a natural network of self-help, helping to build a supportive network; (they are) on the border, but helping, just under the radar.”*

When consumer/survivors earn a livable wage, *“More people in the community are not living in dire poverty and they can find their voice.”* An example was given of a staff hired from the agency membership who has recently joined a high level advisory body.

Training for peer workers

Most agency/organizations’ overall approach to training was consistent (e.g. offer the same types of opportunities and allowances, tailored to the individual’s needs and interests). One suggestion was to have a peer group develop the training.

The OPDI representative cautions agencies against training their own peer workers saying, *“Clinicians can train people to other things, but not peer support.”* OPDI is developing and delivering training in Core Peer Support Skills to 200 individuals from member organizations. They offer certification of graduates and licensing of trainers with the aim of bringing consistency and strengthening the credibility of peer support in the system.

A number of respondents expressed support for recovery-oriented training like “Wellness Recovery Action Plan” and/or “Pathways to Recovery” training, although not exclusively for peer support workers, but for *all* staff. In fact, respondents stressed the need for all staff (front-line and management) to be educated about peer support, consumer/survivor issues, and diversity; many commented on their perception that integration with other staff is one of the biggest challenges of employing peer workers.

Strategies for integrating and supporting peers

- **Employ multiple peers**

“Integrating peers into teams of existing staff... can be a set up for failure, or isolating. This is the case especially when there is only one peer. When there are many peers it is not as much an issue.”

- **Peer group meetings, lunches, etc. for mutual support**

CMHA has a lived experience support group; CAMH has “Unusual Suspects” lunches, open to any employee who is a consumer/survivor; peers from various ACT teams meet as a group.

- **Offer competitive terms of employment and progressive benefits in a healthy work environment**

“Pay a living wage... complete with benefits. This reduces the stress by elevating their quality of life. People who earn honoraria still experience the stresses of poverty.”

- **Treat peers equitably**

“Try to treat (and pay) the peer worker the same as everyone else”; “Make them equal in the team”; and “ensure that the peer worker is treated with the same professional attitude as everyone else.”

- **Do an agency policy audit**

Analyze policies through the lens of a consumer/survivor.

- **Accessibility Standards**

Understand legislation regarding employer’s duty to accommodate employees with disabilities.

- **Be flexible**

Scheduling, the number of hours, and fulltime work options should be considered.

- **Adopt a team based approach**

Team members are key in providing day to day support (to one another).

- **Allow peer support to be peer driven**

PHASE THREE CONCLUSION

Funding issues were recurring themes in the interviews. One agency created a peer support position when they had the opportunity to apply for new project funding. *“We wish we had funding to hire more [peer support] workers. Ideally we would hire a peer worker at the same salary [as other staff]. Limitations of the funding are the problem.”* This agency has delineated distinct responsibilities for the peer support worker, because “it would not be fair” for them to fulfill duties for which they are not remunerated. Another respondent maintains that staff vacancies provide a great avenue to implement the hiring of peers. He adds, *“If there is new money available, then it can be used to create peer programming.”*

One respondent said: *“The peer worker sector will expand because it is effective and also because it provides cheap labour to the institution.... It will be interesting to see if peer workers are able to move up within the institution.”* Another voiced concern that some LHINs *“seem to have the idea that peer support should all be volunteer ‘because there is no money’ and seem to think of it as a way of delivering mental health services for free.”*

Clearly, if peer support is to grow and thrive, endorsements by governmental and funding bodies must have sustainable funding attached to them.

DISCUSSION

Debate regarding best practices and the future of peer support work flourishes in the larger field. The community research team also had much to contribute to the discussion, thereby resulting in a further round of questionnaires and meetings in which they could more thoroughly express their own viewpoints. A summary of that rich dialogue is reprinted here.

Using the term “peer”

In the study, the term “peer support” was used to describe support provided by individuals with lived experience of the mental health system and/or homelessness to individuals and communities with these same or similar experiences. The term “peer support” seemed to be embraced by some, and was contested by a few. For some, the term may simply be used by default (i.e. for lack of another term that is widely understood). The specific use of the term “peer” in a job title inspired spirited debate among members of the research team. Clearly identifying the position as a “peer” position (i.e. requiring lived experience) may draw applicants who might not otherwise apply. This may further the objectives of employment equity and attaining a workforce that includes staff who are reflective of the community served. It also clearly identifies the worker to tenants/clients as someone with lived experience, and, in doing so, conveys a certain type of expertise and credibility. For some, peer support is unique and different from other types of support, such that the use of the word “peer” differentiates the work and role. Including the word peer in the job title was also seen to raise the profile of consumer/survivors in the workforce, which may serve to dispel

stereotypes and reduce prejudice. One of the researchers commented, *“I see that (the peer title) confirms that people who have accessed this system can recover and live independent lives.”*

Some did not support the use of the term “peer” in a job title. One researcher commented that the term “peer support” is not fully descriptive of what peer support workers do. A few noted that each individual may have multiple “peer” groups based on the characteristics that they share with each of those groups; therefore they perceived the use of “peer” in a permanent job title as flawed and inaccurate.

There were also reservations about including peer in the job title because of stigma and discrimination. “Peers” note that they have experienced discrimination in their workplaces, in the sector, and in the wider community. They have also expressed concern that job experience that is labeled as “peer work” may not be valued or recognized elsewhere. These are serious concerns that require careful consideration and action.

Clearly there are excellent reasons to consider both the use and the exclusion of the term “peer” in a job title; what is most important is that agencies include people from the communities they serve in multiple job positions, at all levels of the organization.

“When I began working again in an Alternative Business, the fact that reasons for me being late or away from work would be considered and accepted was very helpful for me; it allowed me to come in and do my work without the added anxiety of wondering if I was going to lose my job. It allowed me to perform better.”
Community Researcher

Self-Disclosure

Within the sector serving people with experiences of the mental health system and homelessness, “peer support”, by definition, requires a worker who self-identifies with those experiences. In addition, hiring processes that value lived experience, seek to promote equity, and create a workforce that is reflective of the community served may include lived experience as a qualification. Individuals must self-identify in order to establish that they fulfill the qualification. In this study, workers providing support to peers also noted that *self-disclosure* is a basic requirement for peer work. Self-identifying is a form of self-disclosure, and self-disclosure is also used in reference to broader sharing of personal information, thoughts, and experiences. Self-disclosure can be very powerful; it can help build trust, strengthen connection, provide inspiration and encourage hope. Workers who were interviewed highlighted the primacy of confidentiality and personal choice in disclosing identity and sharing personal information and experiences.

Some of the data collected in this study hint at expectations by employers and colleagues regarding self-disclosure by workers with lived experience. Agencies, supervisors, and co-workers must be aware of privacy and confidentiality concerns, and respectful of the personal choice regarding the sharing of identity and personal experiences. While it is important to value and support self-disclosure, staff should never feel pressured or pushed to share personal experiences. Thoughtful, reflective discussion about the use of self disclosure could support the work of all staff, who inevitably disclose aspects of personal experience from time to time in

the line of duty. Discussion about self disclosure and related issues may be encouraged within teams, with supervisor(s) and within peer groups.

Professionalization of support

Despite the emphasis on work conditions for paid peer support workers that marked most of the research elements in this project, participants invariably touched on the subject of the organic peer support that unfolds naturally within communities. For example, in the focus group discussions with boarding home tenants, researchers uncovered diverse and meaningful examples of how tenants build relationships and trust in supporting one another while living in boarding homes. Some peer support workers mentioned ways in which they cultivate and promote mutual support within groups and communities. This aspect of the “peer support” role was also acknowledged by a number of the agency representatives we interviewed. One remarked that the peer worker *“can be very effective in encouraging tenants to participate in activities and community development initiatives.”* Another described how the peer worker tended to connect tenants with one another in ways that were mutually supporting. This approach can help communities to thrive and be self sustaining. One of the respondents described two priorities: hiring and integrating consumer/survivors into their staff, and simultaneously supporting an environment in which tenants can take leadership roles, in which the community can identify needs and the solutions.

The very concept of professionalizing peer work is hotly contested by many stakeholders in the field – some are threatened by what they perceive destabilizes institutional/social convention. Others critique it for far different reasons, namely that it abandons the principals of autonomous community development; it betrays the very grassroots movement that birthed the premise on which peer support framework rests. In terms of psychiatric consumer survivor history, this grassroots community developed not just as a complement or alternative to the medical model. It grew, in effect, to organize for social change. The very fact that this community developed to counter-act social, economic and institutional systems in place – that people found a voice and organized against these behemoths, is highly political. As one of the researchers stated, *“Situating something that has historically been grassroots into a formal system inherently depoliticizes it.”* The potential for profound social change withers. For example, some researchers argue that peer workers must have relevant training (such as programs offered by ODPI, Sherry Meade, WRAP, etc), while others oppose creating a training model that may be alternative to conventional academic study but nonetheless still recreates hierarchy and barriers for consumer/survivors. They argue that this type of hierarchy subverts more widespread, sustainable community building efforts. The stratification of peer support (i.e. arranging peers into separate layers or groups) is not without its costs. This is an important caveat.

So how do you allow the two to happen – the natural organic development within the community AND also bring in the formalized element of paid positions? One possible solution is for organizations to hire diverse, compassionate people with lived experience of the mental health system and/or homelessness, who demonstrate networking and leadership skills, and who are invested in grassroots community development. Simultaneously, agencies and

organizations must embrace a spirit of investing in the community. That might take the form of supporting community driven initiatives such as community gardens, food sharing programs and other environmentally sound sustainable projects. It is easier for community members to focus on leadership and development goals when their living standards are at acceptable levels, when elements of the social determinants of health are in place satisfactorily. Perhaps this two-fold approach - giving community leaders access to the resources and tools they need to do their work better , and sponsoring community initiatives that foster hope and lead to positive developments, is the ideal 'model' for best practice.

RECOMMENDATIONS

Community researchers noted that in order to maximize the effectiveness of peer work, major systemic changes must take place.

Implement Anti-Stigma and Anti-Discrimination Work

Most important is a radical attitudinal shift in social service agencies/organizations, at all levels of employment, and in training programs for all public sectors and fields (e.g. health, including psychiatry, nursing, emergency services; social services; community work; police; education, etc.). Anti-stigma and anti-discrimination training, developed in conjunction with served community members, should lead to revised philosophical missions, and also to improved practical service provision. Agencies should also lobby for government-sponsored public education campaigns and mechanisms to eliminate discrimination.

Fully Integrate Recovery Oriented Approaches

Agencies should move away from conventional medical models of service delivery toward a client-centred, recovery-based approach which prioritizes listening to clients and responding accordingly. In so doing, we work towards legitimizing lived experience in general, and specifically in acknowledging that community members can be experts in recovery from adversity, in resilience and resourcefulness, and that they may be well-connected leaders in their own right.

Transform Hiring Practices

By acknowledging achievements gained through lived experience and by prioritizing social, interpersonal, and other ‘soft’ skills, agencies begin to recognize the vital yet frequently elusive qualities that make for excellent support workers. Funders could mandate minimum hiring percentages to reflect the communities served; this would radically change the focus of future hirings in the field. The mechanics of hiring also need to be examined. Where job opportunities get advertised, work conditions and benefits packages offered, and specific wording used in the job posting are as important as the revision of conventional hiring committee practices of rating resumes and selecting interview questions; hiring committees should stress demonstrated lived experience and other relevant and equivalent experience, not just formal credentials.

In revising hiring practices, agencies must somehow develop tools to recognize and rate the aforementioned qualities that make for excellent support workers. Researchers listed creative problem solving, comprehension of social determinants of health and the effects of poverty, an integrated anti-oppression framework, excellent listening skills, empathy, and a demonstrated effort working or volunteering in the community as priorities. Candidates must be comfortable with appropriate self-disclosure, have good supports in place and have a self-awareness regarding boundaries and personal limits. Candidates must be able to offer practical support that is realistic to clients’ situations, and to accept people and their choices.

If the agency determines that particular training is required (e.g. WRAP, recognized peer support training) for the purposes of the job, the employer should be prepared to fund the training. If alternative training is considered a prerequisite for hiring, it will become a barrier for individuals who, in spite of their lived experience, expertise, skills and potential, have not been able to access these opportunities.

Build Healthy and Supportive Work Environments

Flexibility to accommodate working hours, personal leaves, appointments, time off, work distribution amongst teams, etcetera, allow for employees to be more effective and supported in their jobs. Agencies should employ multiple peers, employ peers at all levels of their organizations, and support them to connect with an external network of peer support. New staff need sufficient orientation to the workplace, including policy, procedures, and culture. Job shadowing, regular debriefing meetings with supervisors, and equally accessible training opportunities all help.

Value the Unique Role of Peer Work and Contribution of Staff with Lived Experience

Clinical settings tend to train peers in medical model thinking, language, and approaches. However, it is important that agency/institutions not co-opt ‘lived experience’ or peers, themselves, for their own purposes. The peer can end up being used by agency staff as a representative of the entire client base, rather than the agency staff actually speaking with and listening to their clients as individuals. In this instance, the peer support worker risks being treated as a more accessible version of the client base, rather than the workplace experiencing attitudinal shift and culture change. Nor should the peer be expected to leverage their peer relationship with clients in order to gain “compliance”.

More generally, agencies need to recognize the unique role of peer work, and allow time for peer workers to develop relationships with clients and colleagues before determining if things are ‘working’. Peer support can be goal-oriented, but it defies specific outcomes within strict time frames, which can be problematic in programs that rely on limited timelines for participation. All agency staff should be educated on peer support by peers.

Support and Invest in Communities

In addition to providing individual supports, agencies should foster autonomous, supportive relationships amongst community members or service users. Investing in and supporting capacity building, leadership, and community development will contribute to healthy and sustainable communities.

In conclusion, we offer up the results of our findings, some of which are specific recommendations which PARC may choose to embrace as it moves forward to finalize programs and support services for the new building. Habitat Services will assess its own practices as a social service provider, and investigate the various ways in which we can adapt to the recommendations found herein, and will seriously consider these issues as the agency moves toward developing its new strategic plan in the coming months. We offer these recommendations to the community at large, in hopes that other mental health and housing

service providers will consider the profound impact meaningful employment can have on community members, and the equally profound improvements that connected, experienced employees can bring to program content and delivery, within their own networks and communities.

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APPENDIX I: LITERATURE REVIEW

Introduction

Increasingly, mental health agencies are including peer providers (peers) on their staffs in recognition of peers as a valuable component of a recovery oriented, best practice approach to rehabilitation services for people with mental health conditions. (Gates & Akabas, 2007, p. 293)

Over the past few years, the practice of using peer support has become much more accepted within the social service sector and there is a burgeoning literature on the subject. However, there are great variations in the concept of peer support and in different implementation practices. Generally, peer support is associated with a recovery model that promotes choice.

Some organizations have full-time peer support workers receiving salaries that are commensurate with other staff in the organization. Others view the peer support role as a voluntary contribution, and still others are in the process of developing protocols around peer involvement. While it is widely recognized that peers have much to contribute because of their lived experience, agencies are often concerned with confidentiality and boundary issues.

The following provides information on the history of peer support, approaches to peer support work, and the challenges facing both peers and agencies as they attempt to develop this new field. This document reviews reports, academic journal articles and training program manuals from Australia, New Zealand, the U.S., the United Kingdom and Canada. The final section outlines some of the training that is currently available for peer workers.

Definition

A commonly accepted definition of peer support has been developed by Shery Mead, a leader in the field of training for peer support workers: Peer support involves consumer/survivors sharing relevant personal experience with a consumer currently in the mental health system to assist them to become independent. Through empathetic listening and mutual discussion, choices for treatment and recovery are individually made to suit one's needs. Independent skills to participate successfully in society, such as financial responsibility, self-care, decision making, and social interactions can be taught by example (Mead, Hilton & Curtis, 2001).

It is currently recognized that recovery knowledge or the personal experience of a consumer survivor is not something that can be adequately taught to professionals in an academic setting. Rather, survivors are able to relate to, give feedback, and provide information and suggestions to a consumer that a professional could not (Campbell & Leaver, 2003).

Peer support is based on the belief that people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations. While this belief is well accepted for many conditions, such as addiction, trauma, or cancer, stigma and stereotypes about mental illness have

impeded attempts on the part of people in recovery to offer such supports within the mental health system. (Davidson, Chinman, Sells, & Rowe, 2006, p. 443)

Peer roles take many forms and peer workers are able to provide a variety of services. They can provide one-on-one support, facilitate self-help groups, conduct community outreach and provide education to other staff and medical professionals. Peer workers may work over the phone or on-line as well as in person. They may assist consumers in navigating through the mental health system, work in supportive housing settings, provide informal or crisis counseling. Mental health facilities, social housing providers, street outreach services, and drop in centers are beginning to use peer workers. Some documented benefits to having a peer worker within an organization include:

- More comprehensive and holistic service provision
- Encouragement of clients through personal experience
- Reduce costs (a hotly debated issue)
- Communication bridge between patients/consumers and psychiatric staff, assisting each side to better understand the other

History

Peer support is a natural human response to the alienation and adversity associated with being given a psychiatric diagnosis. Wherein the diagnosis marks us as “different” and separates us from the community, peer support creates common ground and the opportunity for inclusion. Because it is a human response rooted in compassion, peer support is not confined to one time or one era. Peer support has a long history (Deegan, 2006, <http://www.patdeegan.com/blog/archives/000018.php#more>)

While there is no consensus regarding the origin of peer support, many refer to the birth of Alcoholics Anonymous (AA) in the 1930s as a starting point. Bill Wilson and Dr. Bob Akron, both alcoholics, found that helping other alcoholics assisted them with their own sobriety.

Peer counseling is the foundation of Alcoholics Anonymous, Narcotics Anonymous, and similar groups that tap people during their recovery to help others get on the same path. (Ault, A., 2006, http://findarticles.com/p/articles/mi_hb4345/is_6_34/ai_n29281392/)

Others cite peer support examples as early as the late 1700's. After being released from a London asylum in 1838, Richard Paternoster placed an ad in the London Times for other former asylum inmates who were interested in trying to improve the conditions of patients in asylums. The resulting Alleged Lunatics' Friends Society was formed to provide peer support and to advocate for inmates. The society remained active for almost 20 years and had over sixty members. The Lunatics' Friends Society is recognized as a pioneer of organized peer support and a precursor to the psychiatric survivors' movement. (Hervey, N., 1986)

During the 1970s and 80s groups of ex-psychiatric patients rallied in cities across North America to challenge psychiatric treatment provided by the medical establishment. They spoke out

against coercive hospital treatments including electro-shock therapy, over-medication and what they viewed as violations of their rights. In Toronto, the Coalition against Electroshock lobbied for the abolition of electroshock (ECT). Former patients in this city began several independent community initiatives such as drop-in centres, second-hand stores, newsletters, and magazines like *Phoenix Rising*. The term *consumer/survivor* came into use at this time, defining people who had received treatment in the mental health system (in hospital or in the community) as either *consumers* of purchased mental health services or as *survivors* of psychiatric interventions. Some consumers/survivors continue to use the mental health system exclusively, while others seek alternatives to the traditional medical model or combinations thereof.

During the past two decades consumer/survivor initiatives have received funding in a number of countries, including Canada. By 1991, 42 programs had been funded across Ontario and in that year the Ministry of Health provided funding for the Consumer/Survivor Development Initiative (CSDI), now known as the Ontario Peer Development Initiative. The mandate of the original CSDI was to develop a provincial organization that would “tap the skills and knowledge of people who had direct experience in the mental health services system, and provide them with support and employment opportunities.”

Currently there are approximately 60 consumer/survivor initiatives in Ontario. Some are social enterprises or alternative businesses (social enterprises managed and operated by consumers/survivors), while others provide peer support in a variety of settings. While many of the consumer/survivor organizations of the 1970s and 1980s were established in opposition to or as an alternative to the mental health system, peer support work is currently situated within the larger umbrella of the mental health system. There is an implicit understanding that consumers/survivors are receiving assistance from the mental health system and *peer support workers are generally working within the system* to make it more responsive to the people it serves.

The Approach

Self-run consumer programs are being funded at increasing rates, and more recently, training programs for peer specialists are creating new job markets for consumers in a variety of treatment settings. (Bluebird, G., 2004, p. 47)

Peer support workers carry a variety of responsibilities as outreach workers, housing support workers, counsellors, and crisis workers. They simultaneously act as role models by sharing their personal stories of mental illness, by demonstrating coping skills and independence, and by keeping communication lines open between service users and clinical staff in times of crisis. Typically, peer support workers promote a more holistic approach to recovery than the traditional clinical model. They often assist people to make choices about treatment in order to help them regain more control of their lives. Peer workers’ personal experience with mental illness and navigating the mental health system can encourage trust in consumers/survivors facing similar situations. For example, most peer workers have an intimate understanding of the diagnostic process used in the mental health system, and of the potential side effects of

various medications. Explaining vital information such as this in plain language can allow a consumer/survivor the opportunity to ask questions, seek clarification, make informed choices, etcetera. Peer support workers can also educate clinical staff about what it feels like to experience certain symptoms and the side effects of various drugs; hopefully clinicians become more empathetic to their clients' situations and experiences. Other goals of peer work - to encourage consumer/survivor empowerment and to foster independence, can lead to strengthening the larger consumer/survivor community. The peer support worker can also benefit from this work.

When persons who have recovered are hired to work in significant roles as mental health providers, they acquire a sense of identity that is acceptable to themselves and to others. Indeed, it is being modeled right before their very eyes. And, many peer providers have stated that when they feel they are making a difference to improve the lives of others, their own recovery progresses. Furthermore, the participation of consumers in peer program decision-making helps transition people into taking responsibility in the broader community. (Campbell & Leaver 2003, p. 6)

Challenges

While peer support clearly provides many benefits to consumers and mental health professionals, challenges exist as the two groups develop ways of working together.

The integration of peer workers and clinical staff can be difficult. Some individuals believe that the "peer" label sets peer workers apart from all other staff. Peers cannot choose to keep their history of mental illness private and this in itself can be stigmatizing. One way around this issue is for organizations to create job titles without the peer description; however, peer workers are hired for their mental health status and are expected to use their experience with the mental health system in their work. It is generally recognized that individual workers should determine how much of their experience they are comfortable in disclosing and to whom.

Current study findings showed that among some agency staff there is a persistence of stigma with respect to the capacity for people with mental health conditions to work in general and the importance of the peer role in particular. Some respondents voiced the belief that having a mental health condition, by definition, meant that the individual was 'sick' and, therefore, unable to give 100% performance in the workplace. They believed that peers were 'cheap' labor who were unable to deal with the stress of working, whose presence on staff had the effect of 'dumbing down' professional staff, who were unreliable, who could not go beyond their own perspectives, and who could not respond to emergency situations. Others, however, felt that peers "made the concept of recovery real" and they were "a living, breathing reminder that staff's work works!" They believed that peers enhanced the quality of service, helped staff understand clients, increased client satisfaction, increased staff morale, facilitated communication, empowered both clients and staff, and improved the status of the agency in the community. (Gates & Akabas, 2007, p. 297)

Colleagues who harbor prejudices and are not used to working with consumer/survivors may make the work environment difficult for a peer worker. Accommodations that may be made for peer workers such as sick leave entitlements or part-time hours may be resented, particularly if the concept of accommodation is not well understood or accepted in an agency.

Issues related to compensation for peer work may also be contentious. Bluebird (2004) emphasizes the importance of adequate compensation: *"Salaries and benefits should be commensurate with other positions of equal status. Some positions may be created as part time for people who are on disability but should allow for incentives should the individuals wish to transition to full-time work."* (Bluebird, 2004)

Some professionals believe that peer support should be done on a voluntary basis since they fear that peers receiving payment may begin to see themselves as professionals or that consumers/survivors will no longer relate to paid peers. There is also a danger that clinical staff may minimize the importance of peer work, particularly if the work is conducted off-site in places such as coffee shops, restaurants or drop-ins. However, there is growing consensus that peer workers should be fairly compensated for the services they provide, and that paying a peer does not detract from the "peer" quality of the support (Sesula, D., 2000, <http://www.execulink.com/~swaninfo/page0004.htm>).

Boundary issues are frequently cited as a perceived concern, for peer support workers may find themselves working with people who they consider friends or acquaintances. This can be challenging for the peer worker, the consumer/survivor, and for other agency staff if there are no organizational guidelines regarding professionalism in the workplace. Training, for both clinical and peer staff, and the development of appropriate policies within the workplace have proven helpful to integrating peers into the field.

Along with HR policies, practices and structure, study findings suggest that workgroup strategies that build relationships between peer and non-peer staff and clarify the division of labor are important to effective peer integration. The emergent strategies focus on establishing clear channels of communication between peer and non-peer staff to share information related to treatment planning, training on how to communicate effectively, and providing opportunities to increase mutual understanding and support. Thus, workgroup strategies might include (1) formal structures for peer and non-peer staff to share information such as team meetings, one-on-one meetings between peer and non-peer staff, mandatory peer and non-peer entries in case records, mandatory requirements for peer and non-peer staff to read the records for all new clients, or opportunities for peers to participate in staff development and training activities, particularly those related to treatment philosophies and approaches; (2) training for peer and non-peer staff on how to respond to issues around sharing information such as providing staff with an understanding of the importance of the information peers gather about clients to clients' treatment, and offering peers specific ways to explain to clients the conditions under which clients can feel that shared information is protected. (Gates & Akabas, 2007, p. 303)

Training

CSPs should have the necessary qualifications to do the job for which they are hired. Having a psychiatric history is only one of many requirements. Other qualifications may include level of education, knowledge of advocacy issues, past work history, or previous experience related to the job. (Bluebird, 2004, p. 52)

Training programs for peer workers vary in structure and content, depending on the program and on the country of origin. Australia, New Zealand, the U.K. and the U.S. all have national certified training programs with a core curriculum based on a recovery model of support, rather than a conventional clinical model. Training may be provided by non-governmental organizations, peer organizations, mental health programs or government. While most training is done in a classroom setting, some certified training can be found online. The length of training programs typically ranges from 4 days to 12 weeks (from 20 to 108 hours). Most training programs require a basic education such as a high school diploma. The training sessions often use a combination of classroom teaching, storytelling, role-playing, group work, and homework or journaling; they encourage students to engage and network with each other as well as with local community services. Some common content in training programs includes:

- Establishing healing relationships
- Using empathy
- Listening and interpersonal skills
- Telling your recovery story effectively
- Understanding the recovery process
- Setting recovery goals
- Establishing boundaries
- Advocacy
- Conflict resolution
- Role of the peer supporter

Additional content may include:

- Symptoms of mental illness
- Psychiatric medication and side-effects
- Spirituality and recovery
- Trauma and recovery
- Wellness Recovery AP
- Assertive Community Treatment training
- Self – care
- Addiction
- Youth
- Diversity / cultural competency
- Organizational skills
- Addressing stigma
- Decision making
- Leadership

- Crisis support

Summary

Literature demonstrates that both social service agencies and consumer/survivors are grappling with the issues raised by the newly developing field of “peer support”. Debates about using the term “peer” in a job title, about peer roles and appropriate compensation, challenges integrating peers in a clinical setting, and issues regarding stigma and discrimination in the workplace, a general recognition and value of peer support clearly exists. Peer support training programs are being developed in response to the increasing demand for peer support workers, which brings another debate to the table – the professionalism of peer support work and the subsequent effect on service delivery content and style.

Providing employment opportunities and offering recovery based support to consumer/survivors definitely benefits the larger community. However, it is vital for consumer/survivors to remain part of these processes - in planning, developing and delivering new programs. These changes in program development and service provision in the mental health sector signify a new era of partnership between consumer/survivors in the community and mental health service providers in more conventional settings.

Resources

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APPENDIX II: FOCUS GROUP QUESTIONS

1. What does peer support mean to you? [after collecting definitions from the group, we will clarify our working definition for the purpose of this study]
2. What kinds of supports exist in your home?
3. How have you helped/supported another tenant? Have you wanted to help another tenant but couldn't? Why not?
4. How do other tenants help/support you?
5. What supports would you like to see in your home/housing?
6. What jobs, paid or unpaid, are currently being done by tenants at your house?
7. What other jobs could be done by tenants/peers? (For example, jobs that are currently being done by boarding home or outside staff)
8. What would the benefits be to having a peer provide support in your house? What would the challenges be?
9. What skills or qualities do you think a peer support worker should have? What training do you think a peer support worker should have?
10. Would you be interested in having a peer support worker/program in your home? Why/Why not?

APPENDIX III: QUESTIONS FOR INDIVIDUAL INTERVIEWS WITH PEER SUPPORT WORKERS

1. What are your duties and responsibilities?
2. What does peer support mean to you?
3. Are there other peers working in your agency?
4. Who gives you support in your job?
5. What supports are missing in your work setting – for clients? – for you as a peer worker?
6. What strengths and assets do you bring to the job as a peer?
7. What are the rewards of providing peer support?
8. What are the particular challenges with your job? (Prompts: What are the challenges within the organization and also those of the job itself?)
9. What training would you recommend for peer support workers? (Prompt: What else would benefit peer support workers?)
10. What are your thoughts about self disclosure and sharing your identity? (Prompt: With peers and with other staff in the field?)
11. What are the personal challenges/struggles you have providing peer support? (Prompt: What are the emotional costs, if any?)
12. What would some of the challenges/benefits be of having peer support in a housing setting? What should the follow up support be when a tenant moves out?
13. What are your views around peer support workers living in a housing program vs. coming into the house for shifts?
14. What advice do you have for an organization that is trying to incorporate peer support in a housing program?

APPENDIX IV: QUESTIONS FOR INTERVIEWS WITH AGENCY REPRESENTATIVES

1. Does your agency have any peer programming?
 - a. If no, why not?
 - b. If yes, could you describe it in general?
2. How many paid peer positions are available in your agency?
 - a. Are they full time positions with salary and benefits?
 - b. Are they part time positions with hourly wages?
 - c. Are they training/mentoring opportunities with honoraria?
 - d. Are they strictly volunteer positions?
 - e. Other?
3. How do you hire for these positions? Prompts: external job posting? Is there an internal mechanism to offer service recipients access? Other?
4. Please list the job titles that are currently being done by “peers”.
5. How do you give feedback, performance reviews etc to peer workers?
6. Do you have different supervisory structures for the peer positions?
7. What are the benefits to having peer workers at your agency?
8. What are the challenges?
9. How have you made your workplace accessible, flexible and supportive?
10. Could you describe training opportunities you offer peer workers? Prompt: Is there job training available? Mentoring? On-going professional development opportunities?
11. What advice do you have for an organization that is trying to incorporate peer support in a housing program?
12. Any other comments/ feedback?



45 Charles St. E. Suite 101
Toronto, ON, M4Y 1S2
416-972-1010
contact@wellesleyinstitute.com
www.wellesleyinstitute.com

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