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ORIGINAL PAPER

"I Think Peer Support Helps to Demystify People Who Have Mental Health Issues and Helps to Remove That Stigma": Exploring the Defining Characteristics and Related Challenges of Youth Peer Support Through Participatory Research

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Abstract
Despite the emerging body of literature on the benefits of youth peer support, there is also evidence that peer support can have unintended negative impacts on peers themselves. It is important to explore what aspects of the peer role contribute to these difficulties in order to mitigate risks. This paper uses a participatory approach to examine the unique attributes of youth peer practice and the related challenges. We conducted semi-structured interviews and focus groups with both peer and non-peer staff from a community-based youth mental health program that provides peer support services (N = 29). Thematic analyses were completed using QSR NVivo. Analyses capture the defining features and related challenges of the peer support role (self-disclosure, boundaries, role confusion and dynamic recovery), and risk factors that affect peers (stigma, exposure to harm and burnout). This paper contributes to the literature on peer support as well as youth participatory evaluation. The findings will be useful to support the development of improved organizational contexts for peer practice and more effective peer support programming.

Keywords PAR—participatory action research · Qualitative research · Evaluation · Youth · Mental health · Substance use health · Peer support

Introduction

Peer support within youth mental health has been defined as a practice that aligns with the recovery model and involves services provision from a trained peer support worker (peer) who has a common lived experience with their client (Canadian Agency for Drugs and Technologies in Health, 2022). Although research suggests that youth peer support can be beneficial for both clients and peers, emerging evidence has also identified that there continue to be barriers related to effective implementation. This study examines current issues experienced by peers in their role to highlight future directions to enhance peer practice and create better work environments for peers.

Peer support can serve a variety of functions in organizations, including service navigation, skill development, emotional support and evaluation (Gopalan et al., 2017). Although the existing literature on youth peer support is limited (Gopalan, et al., 2017; Kirsch et al., 2014; Ontario Centre of Excellence for Child and Youth Mental Health, 2018; Simmons et al., 2020), evidence is accumulating regarding the potential benefits, including outcomes related to promoting recovery (Gopalan, et al., 2017; Mulfinger et al., 2018), decreasing social withdrawal (Mulfinger et al., 2018), increasing social functioning and expanded relationships (Gopalan, et al., 2017), increased

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optimism (Mulfinger et al., 2018), improving coping skills (Kidd et al., 2019a; Stewart et al., 2009), and increasing autonomy and empowerment (Delman & Klodnick, 2017; Gopalan, et al., 2017).

Despite the potential advantages, peer support is still an emerging practice and youth peer roles are often poorly defined (de Beer et al., 2022, 2023; Hopkins et al., 2021; Simmons et al., 2018). Many studies have reported that there is a need for non-peer staff to better understand the nature of the peer role (de Beer et al., 2022; Simmons et al., 2018) and that this lack of understanding hinders collaboration between peers and other clinical staff (de Beer et al., 2023). This can create challenges for peers in their work (Delman & Klodnick, 2017; Simmons et al., 2020; Walker et al., 2018) and can expose them to stressful situations (Simmons et al., 2020; Tisdale et al., 2021). Further, since the nature of peer-client interaction is more genuine and equal, peers often experience challenges managing the boundaries in their professional relationship with clients (de Beer et al., 2022, 2023).

Peers are often stigmatized in the organizations where they practice (de Beer et al., 2022, 2023; Delman & Klodnick, 2017; Simmons et al., 2018). This is likely due to pervasive societal stigma toward individuals with mental health issues and substance use health issues (DeLuca, 2020; Tam, 2019). Professional stigma towards youth peer support workers has been reported in the research literature, whereby peers experience challenges related to the perception that professionals with a clinical or medical background are superior (de Beer et al., 2022). Youth peer supporters likely also experience age related stigma as has been reported by youth advocates working in the mental health system (Tan et al., 2019). Stigma of mental health and substance use has proven to be an intransigent public health issue (DeLuca, 2020; Tam, 2019) that does not appear to be easily influenced by investments in public awareness campaigns.

Ironically, although peers can be exposed to the negative consequences of stigma in their roles, peer support as a practice may be an important intervention that can support reductions in stigma for both individuals and peers coping with mental health and substance use health issues (Conley et al., 2020; Halsall et al., 2022, 2023; Hundert et al., 2022; Mulfinger et al., 2018). There is a need to examine underlying factors that contribute to success and challenges within youth peer support practice (Delman & Klodnick, 2017) and examine the ways to maximize the benefits of peer support while reducing potential harms. Further, it is important to examine challenges that peers experience in their roles as well as potential opportunities to improve working conditions and supportive workplace practices for youth peers. This information will be helpful for organizations implementing youth peer support services, peer practitioners and policy-makers.

Purpose

This research was implemented as a component of a larger hybrid participatory-realist evaluation that was designed to examine what works for whom, why and in what circumstances. The overall study was grounded in critical realism, whereby there is an assumption there is an objective reality (Edwards et al., 2014) that can only be perceived through our subjective experience (Wong et al., 2013). Phenomena are recognized as being subject to complex open systems (Willis, 2023) and the key to understanding is through the development of theory about underlying mechanisms (Pawson, 2013). The realist components examined how and why peer support is beneficial for clients and peers and were reported in the following papers (Halsall et al., 2021a, 2022, 2023). Since the realist and the participatory methods are iterative, the two approaches were combined (see timeline). In this paper, we discuss the methods and findings related to the participatory arm of the study. The participatory approach was informed by youth participatory evaluation models (see Checkoway & Richards-Schuster, 2003; Sabo Flores, 2008; Zeldin et al., 2012). Guiding research questions were developed in collaboration with staff and are focused on: (1) How does peer support practice differ from traditional case management practice? (2) What are the ongoing barriers that exist for peer supporters in the context of youth mental health services? (3) What is the nature and added value of peer story-telling? Discussion of the nature of peer storytelling in this article builds on previous works describing the added value of peer story-telling (see Halsall et al., 2021b, 2022, 2023).

This research was supported by a partnership with a not-for-profit organization based in Toronto, Canada. The focus of the study was a community-based youth mental health program, which serves young people aged 16–29 who are experiencing intersecting challenges related to a range of issues including mental health, substance use health, developmental disabilities and risk of homelessness. The program is being implemented within one main site and staff (both peers and case managers) deliver services within other locations through partnerships with other organizations. The youth program is underpinned by the psychosocial rehabilitation model and takes a client-centred and values-driven approach. The program provides a variety of services with peer supports woven in, including case management, mental health and substance use health supports, service navigation, social support, drop-in groups, campus-based services (post-secondary drop-in program provided by peers with lived experience of mental health challenges), and housing. This study was initiated the year before the onset of the COVID-19 pandemic,

therefore peer services that were being provided in person, individually and in group settings, had to transition to an online format over the duration of data collection. This paper is focused on the peer support component of the program.

Methods

Participants and Procedures

This study was launched with a participatory workshop in July 2019 (see Fig. 1 for a timeline of the overall study). The workshop took place during an all staff meeting and included peer staff, non-peer staff, the management team and students. The workshop was used to introduce the evaluation project to all staff and to provide information about participatory evaluation principles and the study background. The workshop included an exploratory discussion to capture staff perspectives on the initial design, major issues and research questions of interest within peer support practice. The evaluation content was presented using a Pecha Kucha approach, which involves 20 image slides that are shared for 20 s each (see https://www.pechakucha.com/). This style of presentation increases audience engagement and has been successfully applied within several local youth engagement initiatives (Kelly, 2018). Co-author (TH) facilitated the workshop and then led a 45 min focus group that included all program peer staff (N = 8) and non-peer staff (N = 15) to capture information about how and why the program works. TH is a researcher with experience applying participatory research methods within youth-adult collaborations (see Halsall et al., 2016, 2021a, 2021b). MD (peer co-researcher) is a peer with practice-based experience at LOFT, but also previous experience in research focused on young transitioning out of homelessness, as well as within integrated youth services and youth mental health research (see Halsall et al., 2021a, 2022, 2023; Kidd et al., 2019a; Vitopoulos et al., 2018).

After the initial focus group, follow-up interviews were facilitated with management staff (N = 1) and peers (N = 3). These individuals had also participated in the focus group. These interviews were facilitated to gain more in-depth information. Interviews were conducted in person and over the phone and ranged from 50 to 90 min in length. These interviews were focused on the realist component of the study design and are described in detail within Halsall et al. (2021a). However, substantial codes were derived regarding the experience and challenges of peer support work in relation to the objectives of the current manuscript and are described herein.

TH captured notes during the workshop discussion. Topics related to major issues and research questions of interest were used to draft initial questions. These were then refined by TH and MD. These three research questions were

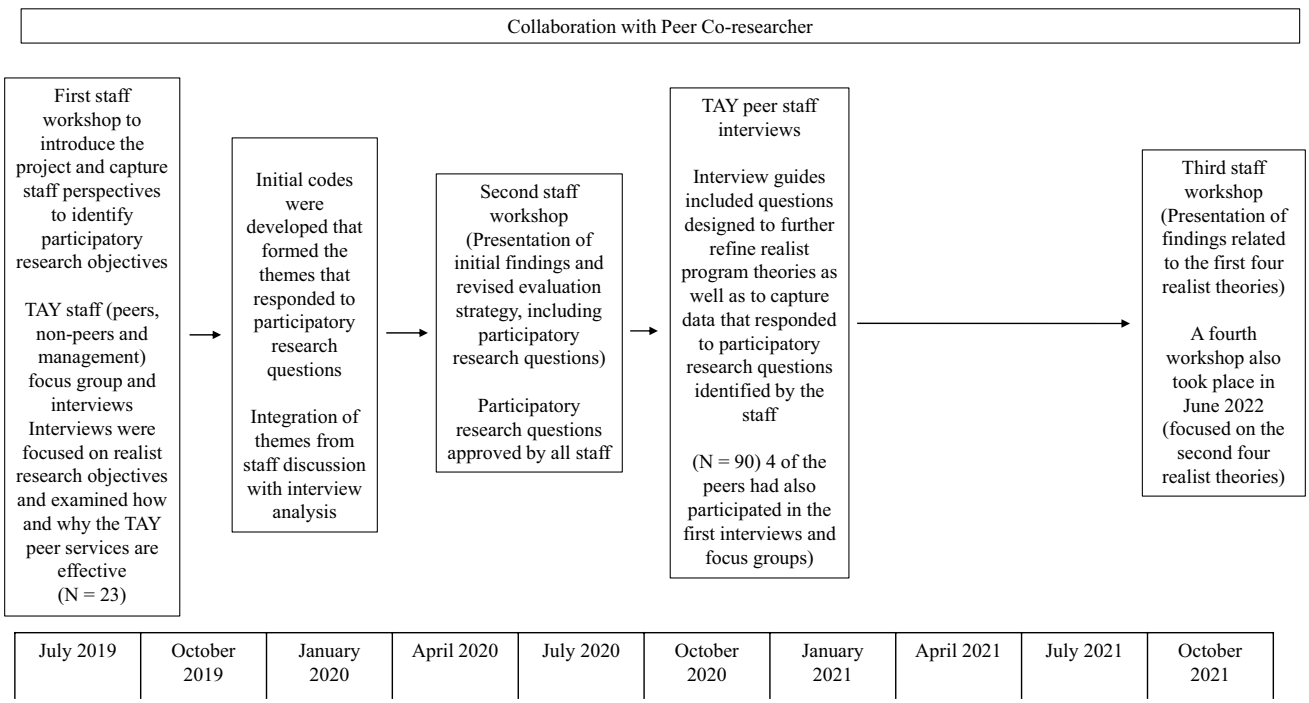

Fig. 1 This figure displays each component of the study within a timeline of the research implementation. The data reported in this paper were collected during the first round of interviews completed in the summer of 2019 (N = 23) as well as the second round of interviews completed in the fall 2020 and winter 2021 (N = 9; six of whom were new participants)

presented to program staff in a second online workshop that was facilitated in July of 2020 along with draft interview guides for their review and feedback. The three research questions and interview guides were approved by the staff participating in the workshop (including peers and management). This research was approved by the Royal Ottawa Health Care Group Research Ethics Board (# 2019007) and all interview guides that were subsequently developed through the participatory approach were approved as an ethics amendment. Informed consent was received from all participants included in the study.

To respond to the participatory research questions derived from the initial workshop, a second round of interviews was conducted with peer support staff between the fall of 2020 and winter 2021 (N = 9; 6 of whom were new). Interviews were conducted through a virtual platform and ranged from 40 to 65 min. Peer staff evolved over the time of the study, so some peers who had participated in the initial focus group were no longer with the organization at the time of the second round of interviews. Also, some new peers had come on board. Subsequent to the first in-person workshop, all other study facilitation and data collection were completed online as the COVID-19 pandemic commenced several months after the initiation of the study. The majority of peers in the program were between the ages of 18–29 years and their roles varied, with some providing peer support along with their case management role and others were responsible for managing housing services. All peers employed in the program had been previous clients.

The interview guide that was used to collect the data for this component of the study as well as the realist component can be found in Halsall et al. (2021a). The following are examples of interview guide questions:

- Is the client relationship with peer supporters different than with case managers? If so, how?
- What factors influence the setting of boundaries between peers and clients?
- How can self-disclosure be used to support peer practice?
- How are peers perceived in the workplace?
- Have you experienced stigma in your role? Please describe.
- How have you used your story in your peer practice? How have clients reacted?

Two more workshops were held in the fall of 2021 and the summer of 2022 to share back and validate findings with the peer staff (see Halsall et al., 2022, 2023 for details). In addition to the broader engagement of peer staff during the four workshops, MD (peer co-researcher) was closely involved in decision-making and implementation within all stages of the research beginning with the initial workshop. This included review of measures and development of interview guide questions, coordination with the youth program, facilitation of interviews, transcription, analysis and interpretation of the data. MD was also involved in the development and facilitation of the second, third and fourth workshop. She served a key role in facilitating engagement from program staff, ensured that measures were relevant to the context and that findings were translated in appropriate language. MD also contributed to key aspects in the analysis and identified two of the program theories within the realist data (see Halsall et al., 2022, 2023).

All interviews were recorded and transcribed. QSR NVivo was used to analyze transcriptions using an exploratory thematic analysis (Braun & Clarke, 2006). The first round of interviews was divided among three separate coders. A second round of coding was completed by TH and a third round of coding was completed by MD. All three coders met to come to consensus. The second round of interviews was coded by TH and then the full dataset was reviewed and codes were revised by MD. Both coders met to review and come to consensus on the final codes of the full dataset.

Results

The findings that corresponded to the participatory research questions culminated in two over-arching themes: (1) Defining features of the peer role and related complexities and (2) Risk factors that affect peers in their roles. Within the first theme, *self-disclosure* captured peer practices that describe the sharing of stories to support client recovery. The first theme also included findings related *to boundaries, role confusion and dynamic recovery*. The risk factors that were captured within the second theme relate to *stigma, exposure to harm on the job* and *burnout* (see Fig. 2 for a thematic map).

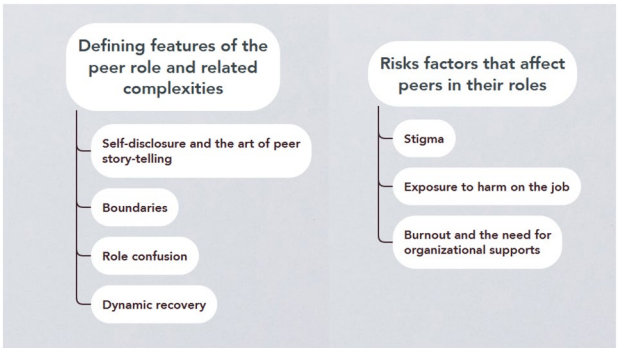

Fig. 2 Thematic map of the overall themes

Defining Features of the Peer Role and Related Complexities

These themes illustrate the unique characteristics of the peer role within mental health and substance use health service provision as well as the nature of the skill set that peers offer. These features are captured in the peers' stories of their experiences in practice.

Self-Disclosure and the Art of Peer Story-Telling

A defining aspect of the peer role is the perspective that they have gained through their shared experience with clients and peer understanding of how to convey this knowledge in a supportive and helpful manner. Peer support staff perceived that self-disclosure helped their clients to access important insights while protecting themselves and their clients from unintended harms within the learning process. Peers described self-disclosure as an art that they refined to maximize client benefit through the development of insight through personal reflection. For example, peers may use their stories to highlight practical information to support clients and to do so, they develop an awareness of what information would be most relevant and helpful in each situation:

> I think that there are parts of the path to recovery that are worth sharing and I think those are mostly milestones and the things that supported getting to that milestone. So like using [the youth program] to … get therapy appointments sorted every week is one of the paths to get there that doesn't quite show those details that are more personal to you. So yeah it's just playing around with that line and understanding what is something that is personal to you and what is something that is effective to share in that moment. P24

According to the participants, peers use their personal stories to reinforce skill development by highlighting the potential impact of these skills that they witnessed through their own personal experience. Peers offered their stories at a level of abstraction, similar to a guiding framework, that helped clients relate to the highlighted knowledge and skills, and how to best apply it to their own stories and unique situations:

> This is a skill. This is how it's used. Then you have a bit of a more personal story to back it up with. That can be more effective. As for types of stories, that's important too. You want to avoid things that are too specific … because it's not about proving necessarily that you have the know-how to talk about something, I don't think that's appropriate. Like, you're not saying, the reason I know, is because I was an alcoholic, blah, blah, blah. It's more like, you are kind of, you're keeping it constructive, you're keeping it specific to the situation and you're not comparing your experience to theirs. P4

Peers described their perception that self-disclosure differentiates peer support from other therapeutic roles such as case management and how this practice contributes to a more lateral relationship (whereby there is a more equal power balance) in comparison with other roles:

> On a peer support level versus a case work level, you're kind of encouraged to self-disclose a bit more… [Case management is] a little bit more of a top-down thing versus peer-support workers are supposed to be right there with them … you can kind of point them in a direction without just kind of setting up very rigid goals and following kind of a formulated approach to support. P22

Peers highlighted that they felt it is important to apply self-disclosure in a way that is not burdensome for the client and that does not cause harm. "There's things in my story which wouldn't help everyone, and could probably, offend or maybe cause relapse… So, you can't willy nilly, tell your life story. It has to be organic and kind of like it where it helps." (P5) In many ways, within the experience of shared empathy in a peer support relationship, clients may encounter difficulty and challenging emotions as they come to know the struggles experienced by their peers.

> I think that the drawback of it, or I guess the negative is that, you need to be very careful with the way you disclose so that you're not giving people, stress over you. This is a weird thing to say, but a lot of people, if you bring up your own like experience, they'll be like, "I'm so sorry." P4

Peers recognized that it is important for them to hold autonomy over how and when to share their stories. They noted that, although they perceived self-disclosure to be an integral part of peer support practice, peers must retain choice regarding how they use their story and what details they share.

> When you look at it objectively, you see a conversation happening here about power, right? So should peers have to share their story upon request? No. That's the short answer. That's the not-complicated-answer. But also, yes. Right? Because it's embedded into the role. It's not what is your story, what do you choose to disclose? That's the part no one can tell you. Yes, you will have to disclose. This is necessary to the role. What you disclose should not be managed... Not just, 'I'm a peer, therefore I disclose.' P1

Although disclosure in the program is optional, peers viewed this as a fundamental practice that differentiates them from traditional case managers.

Boundaries

Peers also described their experiences related to setting boundaries and highlighted the related challenges. These centred on navigating how to self-disclose while maintaining professional distance, ensuring that clients understand their role as a professional mentor and ensuring that clients have clear expectations of the support they will receive. One peer described how setting limits around what aspects of their story they are willing to share, is a practice of setting boundaries:

> For a peer, sometimes there are some walls you can put up in terms of sharing about yourself, sharing about your experiences. You can't go into your whole backstory about things... Instead, you can use your experiences, and be able to share them in a way where you set boundaries for yourself. P21

Peers identified that they felt it is important to set boundaries in their practice so that they do not misrepresent themselves to clients and to uphold the professional working relationship:

> Clients make a joke and they call me dad and stuff like that. Which I really don't like because that is really blurring the line … I want people to learn. But, I also don't want them to see me as a father figure. P5

They highlighted that the boundaries are less clear with a peer role, compared to other clinical or client-facing roles, "Establishing those boundaries and trying to find the best way to support yourself is more difficult than being a case worker… and the professionalism is still here as a peer, but it's so much less clear cut." (P4). Peers described the negative consequences that can occur if clear boundaries are not set and communicated, and how these consequences can impact both clients as well as peers:

> I feel like people who use peer support, not all, not everyone, but they feel like they've been let down by people to some extent. At least, in my experience… And being let down by a peer right away because they didn't want to set boundaries, maybe because it's a weird conversation to have. That can be really like hurtful … But also, there is risk to like autonomy, like health in general for both of you… If a client starts developing some sort of romantic feelings, that's a risk. And even if it wasn't a peer support relationship there is a risk with that. So, I think that setting boundaries right away prevents or can prevent a lot of unsafe circumstances for both people involved. P22

Role Confusion

Another aspect of the peer role that was discussed as a significant issue was role confusion, which peers perceived as relating to a lack of clarity about the nature of the role and the related expectations. These experiences were associated with the dynamic and flexible nature of the role as well as a lack of understanding from other clinical staff. These criteria create the necessity for peers to be able to tolerate a lack of structure and have the ability to adapt. "We're in a space that's not well defined… So, you do have to approach with the ability to be comfortable with the lack of clarity that happens. And flexible to say, okay—my role can change, it will change." (P1).

> When it comes to my role and how I process things, [it is important to be] able to talk through the barriers that I face, that come up in any given week. And it varies so much when it comes to a role this ambiguous. P21

Peers felt that this lack of clarity is reflected in the level of staff knowledge about the peer role, "Sometimes I do feel that there is like a bit of a confusion about what our role is from newer or like part-time staff." (P4) "So basically, at some of our combined sites, we've had to say, 'What do peers do?' Because some of the reception will say yeah, we have peers, and when someone says, 'What's a peer?' They won't have an answer." (P1) Some of these challenges were related to a lack of staff awareness that peers share lived experience with the clients that they are serving, "There's not a really vast understanding that, like, in being a peer support worker, that it also entails that you have your own lived experience." P24.

Dynamic Recovery

Peers perceived that, as with anyone moving through recovery, they themselves do not experience this process in a linear way. Peers described their experience of recovery as a continuous process that involved progress along with setbacks and active engagement in personal growth. This was often described as a defining feature of their experience and influenced them in their roles. "It's a process. It's ongoing. And I'm still going through that process as well, of what we call recovery." (P1).

Peers viewed this dynamic recovery as being interconnected with their ongoing choices and that this is both a learning process and one that allowed them freedom in their direction: "I've done things that I'm not proud of… but I think that that behaviour was in the past and going forward, you have to know that you have time to make different

choices and life is about your choices." (P5) They were able to use this philosophy to inform their practice and to support clients in moving forward and understanding how the recovery process unfolds:

> And if we make a mistake, it's actually an opportunity. Like, it's just how you look at things. And people are like, 'But, I really fucked up." And I'm like, that's an even bigger opportunity. You just literally said you effed up. And now you can say, what am I going to do next? Am I gonna go backwards? Or am I gonna go forwards? P25

Peers argued that part of this dynamic element was a reflection of their age (18–29 years old) and the nature of moving through life and developmental stages. Peers felt this was unique to being a youth peer supporter: "People are at the transitional age years, and you're talking to somebody who seems very much like they're in the journey of becoming an adult, of becoming whoever they want to be." (P4).

Part of being in the process of moving through recovery meant that peers emphasized the need for organizational supports, so that they can access help if they need it,

> [It's important to have] resources to reach out to if the peers themselves need some counseling support. Or even being able to mention to a boss… that I'm starting to feel a bit worse and I'm just trying to work through some personal stuff. P21

Participants felt that peers and organizations need to be able to navigate relapses so that peers, clients and other staff do not experience negative impacts. These strategies should be grounded in a rights-based and harm reduction lens.

> If you're coming to work under the influence, you're breaking rules. [However,] if you're on your own time struggling with substance use and you're saying that this is affecting your being able to come in the mornings right now because you're in withdrawal—that's between you and your boss to say, 'Okay, what are we gonna do about this? Are you gonna take time off to deal with this? Should I cut you out of your days?... Should I be concerned about your safety?' (P1)

Risk Factors that Affect Peers in Their Roles

Participants argued that the distinctive characteristics that, in part, contribute to the effectiveness of the role, are also related to inherent risks and challenges that affect peers both in their functional roles as well as their health and wellbeing. One of the most pervasive and significant risk factors that was described by peers was the stigma they experiences in their roles.

Stigma

Peers described a range of experiences of stigma, including internalized stigma, professional stigma and general stigma of mental health challenges. These experiences created stress for peers in their roles as well as motivation to support system change. Some peers described fear related to the perceptions of their clients when they disclose their past experiences:

> There's the feelings of how clients perceive you, once you start to disclose pieces of your past. Like, maybe if, if it's not evident that like I had worked through, like substance abuse issues, right. And then I disclose that, I fear that in a way, sometimes they might think of me, like poorly, thinking that like, I'm not as qualified to help because like, I've had this sort of past or like, I don't have the sort of formal education that case managers might have. P16

They experienced this stigma as being perpetuated by workplace policies that do not account for peers in equitable ways. One peer, who had moved into case management, described how peers were not included in service recognitions during annual general meetings at his organization.

> You know how every five years, you get like a shout out at … [the] annual/general meeting or whatever…. they don't do that for peers. So, what I'm going to do is when I have my five year thing, I'm going to say 'Well, actually it's been 12 years and you don't count [it]'. P5

Another peer described her experience of discriminatory workplace policies:

> The last organization I worked for… I was told that I was valuable, but I was not treated like I was valuable, I was treated differently. I was treated more like a client or a participant than an employee or a teammate. So you know, I wasn't allowed to have a key to the bathroom on our floor. I wasn't allowed to put notes into the system. You know? I think that this is something that is, why? Why? Why am I not allowed to have a key to the bathroom on the floor that every other employee is allowed to have but me? P25

Peers felt pressure to appear in ideal health and that this pressure was imposed by organizational and professional norms within the mental health system,

> We all have traumatic experiences, and things that we would rather not think about and you know mistakes that we've made, so I think there's a problematic amount of pressure that comes to a lot of healthcare professionals when they're trying to, you know be as quote-unquote healthy as possible, and you are only

> human… especially when I was just starting out as a peer, I felt a lot of pressure to present as healthy and functional all the time. P4

Participants also expressed the notion that it was likely that many non-peer staff also had lived experience of mental health challenges but that they felt that it was not acceptable to discuss this openly.

> I would wager a guess that some of the staff are themselves peers. Or have had experience in the system or have had experiences accessing a psychiatrist or the hospital or whatever. But that's not even being talked about and I think that's a stigma thing. P3

Recognizing the continuing impacts of stigma on peers and within society in general, was a motivation for one peer to move up in her role to focus on changes in the system.

> I think experiencing stigma, I'm the type of person that gets irritated... when things like that happen. And I lose patience with the workforce to adapt. Which is why I've just decided to do more advisory-like peer support roles. The stigma is a motivator for me to do my work because I want it gone. I want people to get paid and I want people to be able to be honest with each other, with themselves, right? So we can actually create solutions that are grounded in reality instead of, like, public appearances. P1

She saw peer support as a key to overcoming stigma as these roles create safer spaces for people experiencing mental health issues. She offered the peer support drop-in program as an instance where clients can experience relief through finding others like themselves,

> I think peer support helps to demystify people who have mental health issues and helps to remove that stigma. Because you're looking around, you're at a drop-in and like 'Oh these people look like me, they act like me, they speak like me.'" P1

Exposure to Harm on the Job

Many peers described experiences in their role that exposed them to possible harm, through increased vulnerability from self-disclosure, exposure through fundraising and re-experiencing trauma. Part of the risk involved with peer support is related to telling one's personal story and how this can affect peer emotional wellbeing:

> It can be sometimes emotionally damaging, because there's risk in expressing your story. There's risk in talking about yourself in that way. There's not a lot of confidentiality for yourself and your story. It's like there's an expectation, like, that's what you're supposed to do, but I feel like there could be a lot of lack of safety of emotional mental wellness, in doing the job. P23

Peers talked about not only using their stories for supporting clients, but also for their organizations to support fundraising efforts, where there is a much higher public exposure and lack of control. They described not having full awareness of the potential consequences of having their experiences shared at that broad level and how that might influence their life and their future.

> When I was a client, I told my story at that time. Looking back, there were things for me that I didn't like about that experience… Because there's a speech writer. If there's a speech writer, is this my story?... This is very common in the not-for-profit sector having story-tellers, having speech writers… It probably was fully explained, but did I understand the long-term implications? P1

Another risk that peers described as being integral to their work is experiencing trauma through supporting others. In the case of the peers in the youth program, some of these experiences were very stressful and upsetting as they were helping others overcome very difficult challenges. One peer described the difficulties of supporting a client who was using substances during pregnancy:

> I don't know how anyone could do this job. And like, just do it on their own. Like, the vicarious trauma. Some of the things that trigger me are some of the things that are just hard. Like, I'm working with one youth today, who, she's pregnant. And she's using, and it's so difficult to watch, because I can't tell her what to do. But I also have to tell her what might happen if she doesn't stop using and I had a mental breakdown yesterday on the phone with my boss, because I was like, it's so hard to like, disconnect and turn my emotions off and just look at her, like, this is my job. Because I'm a human being. And [my boss is] like, 'It's hard. And it comes with the territory.' P25

Burnout and the Need for Organizational Supports

Participants also suggested that chronic exposure to stress can result in eventual peer burnout. Participants described the burnout that can result from the intensity of the peer role and pressure from multiple responsibilities. Peers also described how organizational supports were an important way to help mitigate burnout.

> I think it's really, really hard to avoid burnout. For everyone, always. And I think that peers often have a lot of other things going on in their lives outside of just

like work, right? [They] tend to have like other jobs or school or whatever. P4

As described above, supervision is a key support, but peers also emphasized the importance of having access to paid time off. "I think just the encouragement for taking time off is already a great step that [the youth program] is taking… Because, very much, this is the kind of work you can take home with you and think about going forward.' (P21) These supports were not a standard offering in the peer industry:

Benefits, I know it's unreasonable for some places, and it's just not possible. But you can give them mental health days and still pay them, like, two sick days a year. You get the flu for longer than two days. So, you're telling me, … they need a day off, like, you're honestly going to tell them to take a day off, and you're not going to pay them? No one is going to do that. People got to pay bills, they got families to feed, they got to feed themselves, you know what I mean? Like, it's, you need to, you need to support them, you need to take care of your staff. P25

Discussion

This paper examines the participatory component of a larger hybrid-realist evaluation of peer services for youth experiencing complex health and social challenges. This paper describes the strategies designed to address research questions identified by staff including: (1) how peer support practice differs from traditional case management, (2) identifying the barriers for peer supporters and (3) exploring the nature and value of peer story-telling. Our findings are centered on the current issues affecting peers in their work and illuminate potential recommendations to enhance working conditions in the future. Our main analyses are centered on the defining features of youth peer roles in mental health services as well as the related risk factors. They highlight key issues such as challenges related to the practice of self-disclosure, setting clear boundaries, the need for better understanding of the peer role and considerations related with the process of recovery. Our findings also draw attention to the inherent risks that peers are exposed to, including experiences of stigma, and burnout.

A central component of peer support work is the use of self-disclosure to support client insight and direction in moving forward through their recovery. Although self-disclosure can be critical in helping clients move forward, our findings demonstrate that this practice can place peers in vulnerable positions. It is necessary for peers to have a clear understanding of and autonomy over the use of their story (Daley & Egag, 2019), especially where their story and personal health information becomes public domain, like in fundraising or media. Since stigma continues to be a significant issue in the mental health sphere as a whole and in the peer support sector in particular, young people may experience discrimination (Halsall et al., 2021a) and this could have a harmful impact on their career and social development. In the Honest, Open, Proud-College Intervention, a peer support program that is designed to support college-age students' mental health, a key component of the approach is focused on strengthening self-efficacy with respect to disclosure of mental health issues (Conley et al., 2020). This form of skill development would be helpful to support peers both in their practice and in navigating other contexts, such as requests for story-telling for fundraising purposes.

Another key issue identified by the peers was the need to establish clear boundaries in their roles and in their relationships with clients. Other research has identified that boundary setting is a significant practice to develop in peer support work and that the peer role straddles a line between other professional therapeutic relationships and informal friendships (Simmons et al., 2020; Tisdale et al., 2021). Although, it is necessary for clients to understand that peers are not friends, since their interactions can be more casual, they can support client social skill development and greater chances to develop new social networks (Halsall et al., 2022). Similar to the notion of setting boundaries, there is a range of studies that have identified that, within mental health practice, the youth peer role is not well defined or understood by practitioners and clients (de Beer et al., 2022, 2023; Delman & Klodnick, 2017; Hopkins et al., 2021; Kidd et al., 2019b; Simmons et al., 2018, 2020; Vitopoulos et al., 2018; Walker et al., 2018). However, staff training and the development of clear policy can alleviate these issues (Kidd et al., 2019b; Vitopoulos et al., 2018).

Our findings emphasized that peers were themselves continuing to move along a dynamic path to recovery even while they were in their practitioner role serving clients. This had implications for the development of their role and the supports that needed to be put in place. The stress that peers experienced related to feeling they had to represent themselves as fully healthy and recovered is an issue that has been identified within other programs (Simmons et al., 2020). Yet, the peer role also provides peers with a meaningful career opportunity and this can be protective when they are struggling (Halsall et al., 2023; Simmons et al., 2020). Regardless, it is important to establish processes to ensure that peers can access the help they need in a timely manner (Halsall et al., 2023; Vitopoulos et al., 2018) and receive benefits. Within this program, when peers are on-boarded, they are offered access to external mental health supports in circumstances where it has been identified as being beneficial (Halsall et al., 2023).

Previous research examining peer experiences has demonstrated that they may not receive the same respect as other staff in their organization (Delman & Klodnick, 2017). These experiences of stigmatization are intertwined with exposure to other challenging and stressful situations that can re-traumatize peers (Simmons et al., 2020; Tisdale et al., 2021) and challenges within the role can lead to peers leaving their position (Vitopoulos et al., 2018). To mitigate these issues, it is important for organizations to collaboratively develop and define roles with peers, other mental health and social service practitioners and researchers (Simmons et al., 2020). Engaging peers in the development of organizational structures strengthens internal practice and serves to support peer personal development and career growth (Halsall et al., 2023).

It is important to examine how the issue of mental health stigma is addressed at a societal level and it may be useful to examine concepts in the area of public health and policy research to inform future initiatives. If we would like to make substantial changes in the lives of peers and other individuals experiencing mental health stigma, we must first acknowledge that mental health is influenced by social determinants and examine policy change in order to make progress at the population level. Further, elevating initiatives developed in collaboration with those with lived experience and the innovative application of peer support can help to develop effective interventions to reduce stigma in the future.

Peer practice itself represents the working conditions for individuals moving forward in recovery. The issues raised in this paper highlight the important need to create healthy and supportive work environments for peers. These environments stand to make significant positive or negative contributions to a peers' overall health and they should be recognized as opportunities to extend previous mental health supports and continue to advance individuals coping with mental health challenges as contributing members of society. Future research should continue to examine efforts to improve fidelity to effective peer practice and program implementation while maximizing benefits to peers themselves.

This research used a strong participatory model, whereby our peer co-researcher (MD) was closely involved in all stages of the research and we engaged broader staff involvement in key decision-making around the selection of research questions and tools. We also gathered staff feedback on the first two rounds of findings (see Halsall et al., 2022, 2023). There were also some limitations. For the data presented in this paper, we were not able to facilitate a third participatory workshop to review the last grouping of findings as the grant funding had ended. For convenience, the original focus group was embedded in a staff meeting. This allowed all program staff to participate, but since it was a very large group, not all staff members contributed to the discussion. Finally, this research took place over the course of the COVID-19 pandemic in which Ontario experienced significant restrictions for accessing communal spaces. As such, program processes and services were required to pivot to an online format for the majority of the data collection period. This may have affected both study participation, and findings may be more reflective of this transitional program delivery period rather than typical programming processes.

Conclusion

This study represents a participatory approach that can inform research design in evaluation of youth-focused interventions in future. It also brings attention to key issues that need to be addressed when developing peer support programming in youth mental health. This study offers insight to consider youth peer practice as the working conditions of young people coping with mental health issues and an opportunity to think more holistically about how to create healthier environments beyond health services. We hope that this study contributes to creating stronger organizational supports, healthier contexts for peers going forward and the development of more effective peer mentorship practices.

Author Contributions TH was responsible for the conception and design of the work, data collection, analysis, drafted and revised the manuscript, and approved the final submitted version. MD made substantial contributions to the design of the work, data collection, analysis, substantively revised the manuscript and approved the final submitted version. LH, AW and JH substantively revised the manuscript and approved the final submitted version. KM made substantial contributions to the design of the work, substantively revised the manuscript and approved the final submitted version. All authors have read and approved the manuscript.

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Declarations

Competing interests The authors declare that they have no competing interests.

Ethical Approval This study protocol has been approved by the Royal Ottawa Health Care Group Research Ethics Board.

Informed Consent Informed consent was received from all participants. All procedures were performed in accordance with relevant guidelines.

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