CENTRE FOR INNOVATION IN PEER SUPPORT

Understanding Peer Support:
A Proposed Core Service in Ontario

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*In **2020**, in Ontario, the Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System **identified peer support as a proposed core service** for people with low to severe or complex needs (Government of Ontario, 2020).*

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About the Centre

Support House's **Centre for Innovation in Peer Support** provides wellness based, peer-led self-help and social connections programming to community members; and support to organizations who have peer staff, through training in peer-support program implementation, capacity-building, evaluation, research, knowledge brokerage, and quality improvement. The Centre is dedicated to building the capacity of People with Lived Experience, Family/Caregivers, Peer Support Workers, Peer Support Supervisors, Health Service Providers, Regional Mental Health & Addiction Systems, and Provincial Healthcare Systems.

Where we came from – Our History

Growing from its original identity as a Consumer Survivor Initiative in 1999, the need for the support and training of agencies providing authentic peer support was identified. As a result, the Centre has evolved to become a "Benchmark of Excellence" in peer support and the meaningful engagement of lived experience and family/caregiver co-design. The Centre for Innovation in Peer Support has been engaging and supporting 11 Mississauga Halton LHIN funded & accredited Health Service Providers (HSPs) plus regional, provincial, national, and international collaborators. The HSPs include hospital psychiatric inpatient units, addictions residential treatment, supportive housing programs, central access, employment support programs, justice, community mental health and addiction providers, and self-help education and support groups.

Supporting People Engaging in Services

The **Centre's Peer Programming** stream offers quality regional programs that are designed, developed, implemented, and evaluated by people with lived experience. This stream is focused on peer-led psychosocial and rehabilitative programming. Together, we build community and connection through creating safe spaces to heal and grow for people navigating mental health and substance use/addiction challenges, as well as supporters/families.

Supporting Provincial, Systems & Partners

The **Centre's Provincial, Systems & Partner** stream continues to evolve, listening to input from our stakeholders across the province, and using QI processes to pivot, pilot, evaluate and then scale and spread; we have been able to identify gaps and needs within the system. Our full programing is offered through our **Virtual Learning Centre & Resource Hub** which support the most current, best practices in Peer Support.

Through our **Virtual Learning Centre**, we offer trainings, consultation, our Peer Professional Development webinar series, and provincial communities of practice. Our **Resource Hub** is home to our toolkits, models, and resources. These offerings support the practice and implementation of Peer Support within Ontario.

About Support House:

Support House is directed by our core values. They guide our agency's decisions and actions, unite our staff, define our brand, and inspire our culture. We put people first – our supports are person directed. We connect and engage and start conversations to build and maintain relationships. We focus on health and wellness practices to inspire our culture. All employees are required to adhere to our Oath of conduct tied to our values.

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BACKGROUND

The Journey of Peer Support in Ontario

It is reasonable to assume that various forms of peer support have existed throughout history, as people turn to others with similar experiences for support. One of the first medical recordings of peer support was recorded in Paris France by Phillipe Pinel in the 1700s. Jean-Baptiste Pussin, a recovered patient at a hospital became governor of the hospital and made it a policy to hire recovered patients, Pinel, the head physician documented the results of this practice and found that peer staff would treat other patients more humanely (Davidson et. al, 2012).

In **1971** the **first Canadian peer support service**, the Mental Patients Association was established in Vancouver (O'Hagan et. al, 2010). Consumer based groups and programs began emerging across the country.

Beginning in 1970s - In response to mass de-institutionalization the Consumer, Survivor Ex-Patient Movement began, with groups organizing across North America to:

- Bring change to the mental health system
- Educate other ex-patients and the public to challenge stereotypes about mental illness
- Advocate for patient rights
- Create alternatives to psychiatric institutions (including consumer survivor initiatives)
- Provide formal and informal peer support
- Network and connect with other ex-patients, curating magazines and newsletters (Ontario Human Rights Commission)

The Consumer, Survivor Ex-Patient Movement worked independently of the current mental health system of the time, and had two areas of focus: peer support (to support each other and recover from their experiences), and political action (to change the people and systems affecting their well-being) (O'Hagan et. al, 2010).

This movement played a key role in the future changes to the Mental Health Act, and the establishment of the Psychiatric Patient Advocate Office (Ontario Human Rights Commission; Hartford et. al., 2003). It also was instrumental in the Psychosocial Rehabilitation and Recovery Movements (Piat & Sabetti, 2012; Davidson, 2016), the creation of government funded Consumer Survivor Initiatives, and other mental health and addiction reforms in Ontario and Canada (Ontario Peer Development Initiative; Ontario Human Rights Commission; Hartford et.. al, 2003; Piat & Sabetti, 2012).

1990s - During the 1990's funding for consumer run programs and organizations in Ontario became available.

In **1991** the Consumer Survivor Development Initiative (CSDI) was created to support Consumer Survivor Initiatives and build a consumer survivor sector. Its existence provided key support to the reform process underway at the Ontario Ministry of Health and Long-Term Care. In 2001 the CSDI became the Ontario Peer Development Initiative (OPDI). OPDI's current mission is to acquire, understand and amplify the unique and distinct voice of consumer survivor organizations across Ontario.

In **2007** the Mental Health Commission of Canada (MHCC) was created. In 2010 they launched their Peer Project and published *Making the Case for Peer Support* based on an international literature review, surveys of peer support workers and focus groups with over 600 Canadians. This led to the creation of the **Guidelines for the Practice and Training of Peer Support** (2013), which identified seven key **Values of Peer Support,**

Principles of Practice as well as essential skills, knowledge and training for Peer Supporters. In 2016 Making the Case for Peer Support was published in its second edition.

In **2010** Peer Support Canada – Formerly known as Peer Support Accreditation and Certification Canada was created with the aim of continuing the work of the MHCC in peer support and promoting the growth, recognition, and accessibility of peer support (Peer Support Canada -b). Peer Support Canada developed a comprehensive certification process and auditing tools for training adapted from the MHCC's Guidelines for the Practice and Training of Peer Support. They further enhanced the Principles of Practice for Peer Supporters, and the **Core Competencies** of Peer Workers. Peer Support Canada also created a **Code of Conduct** for Peer Support.

2015 – Support House's Centre for Innovation in Peer Support grew out of the Enhancing and Sustaining Peer Support Initiative of the Mississauga and Halton LHIN and the local CSI Teach, Empower, Advocate for Community Health (TEACH).

The Centre undertook a quality improvement and research process to better understand and develop role clarity for Peer Supporters. This led to the development of the **Peer Support Values in Action**, 17 tangible action statements that were validity and reliability tested.

Through this body of work, the Centre also finalized the **Peer Support Integrity, Quality and Impact (PSIQI) survey** which measures integrity of peer support services, perception of quality of service and the impact peer support, from the self-reporting of people engaging with peer support services. Support House's Centre for Innovation in Peer Support supports the most current, best practices in Peer Support through their Virtual Learning Centre & Resource Hub.

RESOURCE HIGHLIGHT:

THE HISTORY OF MENTAL HEALTH & ADDICTION PEER SUPPORT:
A CANADIAN CONTEXT

Visit our Resource Hub for a more detailed account of mental health & addiction peer support in Canada

Recognition of Peer Support in Ontario

Peer Support has been increasingly recognized as a distinct profession that adds unique value to the larger system of care from government bodies, organizations, and those who engage with services. This has led to peer support being identified in a number of government reports, Ontario program standards, and is currently a proposed core service by the Government of Ontario in their *Roadmap to Wellness.*

In **2010**, the Select Committee on Mental Health and Addictions, made up of provincial MPPs from the province's three major political parties published their final report, *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addiction Plan for Ontarians.* In this report the Select Committee recommended that **"Mental Health and Addictions Ontario should ensure that institutional and community-based service providers actively seek to involve peer support workers in all aspects of service delivery"** (Ontario Select Committee on Mental Health and Addictions, 2010).

In **2011** Ontario released *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. "It articulated six principles, including that of "person-directed services" and identified that "people with lived experience of a mental illness or addictions, and their families, bring their strengths, wisdom, and resilience to their care. They must have a voice as essential partners in system design, policy development, and program and service provision, and the opportunity to make informed decisions about their personal care and support" (Cramp et al., 2017). **In the pursuit of timely, high-quality, integrated, and person-directed service developing and implementing best practices and standards across sectors to support peer and family support was identified as a key strategy** (Ontario Ministry of Health and Long-Term Care, 2011).

In **2012** the Mental Health Commission of Canada released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*, based an earlier proposed framework, *Towards Recovery & Well-Being: A Framework for Mental Health Strategy for Canada*. This 2012 strategy outlines recommendations for action to create the mental health system envisioned by the framework produced in 2009 (CMHA Ontario). **Recognizing peer support as an essential component of mental health services was identified as a priority** (Mental Health Commission of Canada, 2012).

In **2020**, in Ontario, the *Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System* **identifies peer support as a proposed core service** for people with low to severe or complex needs (Government of Ontario, 2020).

Ontario Program Standards

In addition to the aforementioned reports, peer support is expressly included in:

- Ontario Program Standards for ACT Teams, Second Edition
- A Program Framework for: Mental Health Diversion/Court Support Services
- Program Policy Framework for Early Intervention in Psychosis

Alignment with Ontario's Vision for Health Care: The Quadruple Aim Framework

Ontario is working to create a "system that is integrated, innovative, efficient and able to respond to the short- and long-term needs of our patients … This new vision for health care in Ontario is well-aligned with the 'Quadruple Aim,' an internationally-recognized framework that designs and delivers an effective health care system" (Premier's Council on Improving Healthcare and Ending Hallway Medicine, 2019).

(Frontenac Lennox & Addington Ontario Health Team)

The Quadruple Aim Framework seeks to:

1. Improve the patient experience;
2. Improve the health of populations;
3. Reduce the per capita cost of health care; and,
4. Improve the work life of providers.

The delivery of peer support services aligns with all four objectives of the Quadruple Aim Framework, as detailed in the impact to people engaged with peer support services and the benefit to the system (see below). This alignment further validates the impact, efficacy, and value of peer support as a proposed core service in Ontario.

The Value of Peer Support

CMHA Waterloo Wellington's Centre for Excellence in Peer Support conducted a literature review examining the value of peer support. They concluded that peer support has the following impacts (Philips):

Benefit to Those Engaged with Peer Support Services:

- Reduction in symptoms
- Decreased substance use
- Increased self-efficacy
- Development of coping and interpersonal skills
- Adoption of healthy behaviours
- More empowered and hopeful
- Improved daily functioning and quality of life
- Increased goal setting and recovery planning
- Improved social functioning and expanded social networks
- Increased ability to reframe experience and re-construct identity
- Increased medication adherence

Benefit to the System:

- People who access peer support have fewer and shorter hospitalizations and a reduced need for intensive mental health services, saving the healthcare system money
- Accessing peer support increases service-user satisfaction with treatment and leads to better communication between service-users and care providers
- Peer supporters provide authentic empathy and validation not offered by other mental health providers
- Peer staff and volunteers are able to connect with difficult to engage individuals, leading to increased service utilization
- Peer supporters model recovery, decreasing stigma and altering attitudes among mental health providers
- Services become more recovery-oriented and person-centered when they employ peer staff
- Involving peer staff in systems-level planning leads to more innovative policies and programs

Click here to see CMHA Waterloo Wellington's *The Value of Peer Support*

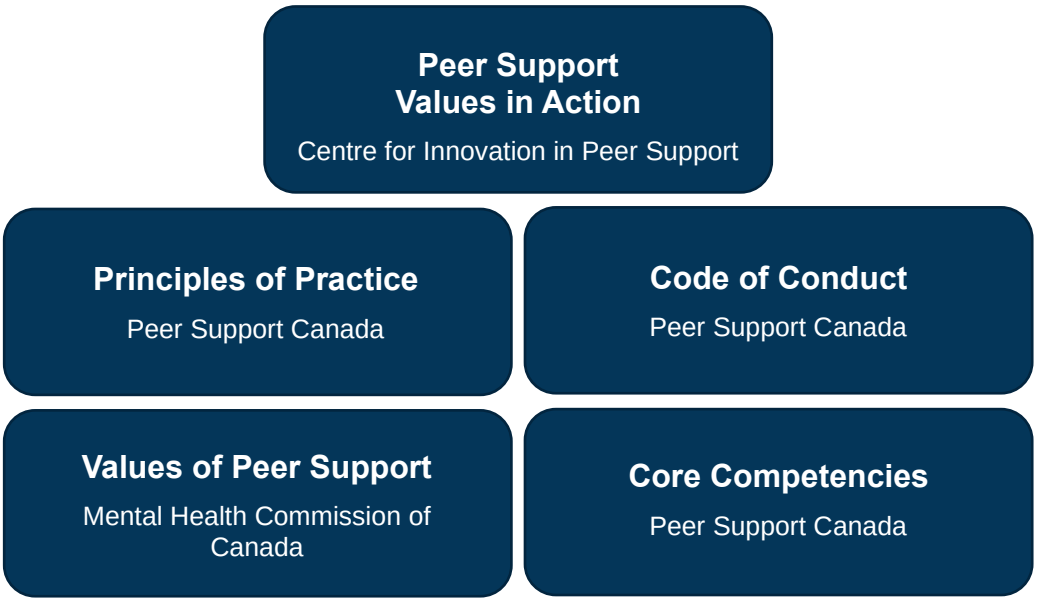
PRESENT DAY

Differentiating Peer Support Practice

Guiding Standards

The practice of Peer Support is currently unregulated. This means that the provincial government has not defined peer support, mandated that supporters be accountable to a governing body or have specific education/training prior to providing support.

The Centre identifies five widely recognized guiding works as the **Guiding Standards of Peer Support**. Together, they set the foundation, identify necessary competencies, guide professional boundaries and identify authentic, values-based, best practices that uphold the fidelity of peer support. These works have been compiled by the Centre, for ease of reference, in the Guiding Standards of Peer Support document. This document can be found on our Resource Hub (see additional resources).



Introduction

Identifying the Necessity of Differentiating Peer Support Practices

The role and presence of peer support has been evolving over recent years (Davidson et al., 1999; Daniels et al., 2010).

Consumer/survivor initiatives were initially formed as a branch of the civil/human rights movement for people to mutually support one another in their recovery of negative experiences, inhumane treatment and injustices within traditional mental health services (Mead & MacNeil, 2004).

There is now a shift to the implementation, and integration of peer supporters within systems of care as providers who utilize their own lived experience to support others with similar experiences. Peer support services continue to be recognized by governments and systems globally (Daniels et al., 2010) as they have been shown to enhance and promote self-management, skill development and positive health outcomes (Fortuna et al., 2022).

There is tension, conflict and challenge among those that identify as peer support workers (under various official titles), organizations, and communities in their understanding of peer support. The evolution from informal and mutually-offered support to peer support being integrated as a practice which is formally embedded within systems, with a designated provider and receiver of service "has been the source of considerable tension and debate within the consumer community" (Davidson et al., 2006). While some view integration with the system as validation of the efficacy of incorporating lived experience voice and peer support values in care, others are concerned that peer support will shift to resemble other system services that the consumer/survivor movement was initiated in response to (Davidson et al., 2006).

Currently there are many definitions of peer support in existence. Broadly peer support is defined as, "emotional and practical support between two people who share a common experience, such as a mental health challenge or illness. A Peer Supporter has lived through that similar experience and is trained to support others" (Peer Support Canada - a). Various definitions, interpretations of the role, and approaches create inconsistency and confusion. Without consistent, common language and a way of distinguishing what support is offered, and how support is being offered, "peer support" has become an ambiguous umbrella term. **Without clarity, those who choose to implement peer support, work in peer support and those who choose to engage with peer supports have different expectations of conduct, ethics and service delivery.**

Categorizing Peer Support Practice

Over time there has been several attempts to categorize peer support practice. There are similarities throughout authors' categorization however, rarely does there appear to be a consistent framework that is widely accepted. Some authors focus on service delivery settings, others on formality and mutuality, and others concentrate on program oversight. **Throughout these various reviews, articles, resources and guides, one thing remains consistent; the need to acknowledge that peer support has more than one approach to service delivery.**

The Centre for Innovation in Peer Support reviewed several widely-accepted, and well-referenced proposed categories while also considering the abundance of interactions we have had in our professional development and training spaces, provincial peer support communities of practice, and independent consultations with peer support workers and

system leaders. The conclusion of this process was the identification of two distinct practices under the peer support umbrella:

1. One in which consumer/survivors gather naturally and informally, and their relationship is based in reciprocal, mutual aid, and possibly friendship. These supports are often grassroots, not integrated into mainstream systems and independently operated by people with their own living/lived experience in paid or volunteer positions (Blanch et al., 2012; O'Hagan et al, 2010; Trainor & Reville, 2014; Fortuna et al., 2022; Barber et al., 2008).
2. The other occurs when those with personal lived/living experiences are employed, or volunteering in mainstream/traditional services and assume designated roles to support others with similar lived/living experiences (Fortuna et al., 2022). This support is an intentional service provided where there is an identifiable 'giver' and 'receiver' of care, supported by mutual agreement (Fortuna et al, 2022; Davidson et al, 2006; Repper & Carter, 2011).

Both of these practices are aligned with values-based peer support as they are both guided by the *Guiding Standards of Peer Support*.

It is imperative to note that this is not a hierarchy. The Centre for Innovation in Peer Support recognizes, understands and believes that both practices have incredible value and provide distinct, irreplaceable support for people who engage with them. We also believe that the tension and conflict experienced in systems where peer support is present has the potential to be resolved by identifying the different ways in which peer supports may exist as distinctly different. While these practices remain identified as synonymous and interlocked there will continue to be conflict among supporters and providers as to how peer support ought to engage, respond, and operate. By identifying them as separate, these practices can maintain fidelity to their unique philosophies, and offer differentiating service delivery models and relationships with the larger system without debate over a single 'correct' response.

Distinct Peer Support Practices Present Day

Intentional Consumer/Survivor Mutual Aid

Consumer/survivor initiatives were formed as a branch of the civil/human rights movement, "in which people affiliated around the experience of negative mental health treatment. (e.g., coercion, over-medication, rights violations, as well as an over-medicalized version of their 'story')" (Mead & MacNeil, 2004). Initially, the shared experiences in these settings were those of treatment, rather than of the mental health and/or addictions concerns they were experiencing (Mead & MacNeil, 2004).

Mutual aid acknowledges that the systems we live in do not meet everyone's needs equitably, and that these needs may be met together as people with similar, shared experiences (Izlar, 2020). The self-help, intentional consumer/survivor mutual aid relationship was created as a counterbalance to what is referred to as the 'service paradigm'; a belief that the only way for those with mental illness to find wellness/recovery is from the receiving of service from a provider (Trainor & Reville, 2014). These consumer/survivor supports are distinct in their organization and approach as they are informal and naturally occurring, based in reciprocal, mutual aid and sometimes friendship (O'Hagan et al, 2010; Davidson et al, 1999; Repper & Carter, 2011; Trainor & Reville, 2014; Sunderland et al, 2013).

Intentional consumer/survivor mutual aid is characterized by people informally and voluntarily coming together as equals to mutually listen, provide and receive support

reciprocally (Davison et al., 1999; Fortuna et al., 2022; Izlar, 2020; Mead et al., 2001; Repper & Carter, 2011; Sunderland et al., 2013; Blanch et al., 2012). This intentional relationship benefits both parties as they come together to meet common needs/goals, overcome challenges and barriers, and bring about desired social and/or personal change (Fortuna et al., 2022; Izlar, 2020; Mead et al., 2001; Repper & Carter, 2011; Davidson et al., 1999; Blanch et al., 2012).

The relationships created in these spaces are conducive to forming supportive, personal connections that may be identified as friendships (Sunderland et al., 2013). In this relationship "neither [person] is more experienced or better prepared to offer support than the other. This is where we see true mutuality and reciprocity between people who are on a journey of similar life challenges who come together to support one another. Hence, the authentic nature and mutual benefit that comes from empathetic support is more identifiable" (Sunderland et al., 2013).

Intentional consumer/survivor mutual aid is often grassroots, not integrated into mainstream systems and independently operated by people with their own living/lived experience in paid or volunteer positions (Blanch et al., 2012; O'Hagan et al, 2010; Trainor & Reville, 2014; Fortuna et al., 2022; Barber et al., 2008). These supports are not explicitly part of a service system as these services often see independence from formal systems of care as central to their operation (Blanch et al., 2012; Mead et al., 2001; Stewart 1990; Barber et al., 2008). Typically, these services are not funded by government and so alternative means of funding are often explored to cover the costs of their activities (Blanch et al., 2012).

Professional Peer Support

There is increased evidence that peer support services delivered in healthcare settings successfully enhance and promote self-management, skill development and positive health outcomes (Fortuna et al., 2022). Peer support has continued to gain traction as a service recognized by governments, and with that funding continues to be provided to support the implementation and sustaining of peer support programs within systems of care (Daniels et al., 2010). Many nations including Australia, New Zealand, United Kingdom, and other European nations have employed peers as service providers (Fortuna et al., 2022).

Mead and MacNeil, 2004 identify that, "Clearly this role has been beneficial in acknowledging the expertise of lived experience. It has also offered recipients a forum to speak about their experience differently, be exposed to strong role models, and develop new skills and strategies to help them heal and recover. Peer services, if done well, can provide hope, role modeling and simple safe strategies for recovery." In order to do this well, it is of the utmost importance that services stay true to the fidelity and integrity of peer support (Mead & MacNeil, 2004).

Peer support provided in mainstream services provides the opportunity to share the unique, lived experience perspective to influence providers and services, humanizing rather than overmedicalizing people's experiences (Mead & MacNeil, 2004). Literature also identifies that "services become more recovery-oriented and person-centered when they employ peer staff" and that "involving peer staff in systems-level planning leads to more innovative policies and programs" (Philips).

The practice of professional peer support is emotional, social and/or practical support (Solomon, 2004; Repper & Carter, 2011; Fortuna et al., 2022) delivered by mutual agreement (Fortuna et al., 2022) by persons who self-identify as living/having lived with similar circumstances and/or challenges (Solomon, 2004; Repper & Carter, 2011; Fortuna

et al., 2022). Professional peer support workers have engaged in training and skill development to enhance their ability to support empowering and empathetic relationships with others in their pursuit of self-determined wellness and/or change (Solomon, 2004; Repper & Carter, 2011; Fortuna et al., 2022; Daniels et al., 2010).

Professional peer support is when those with personal lived/living experiences work or volunteer in designated roles in mainstream/traditional services (Fortuna et al., 2022) while "ensur[ing] that the critical aspects of hopefulness, recovery-orientation, empowerment, non-judgmental acceptance, and trust are promoted within the peer support relationship" (Sunderland et al., 2013).

Professional peer support is an intentional service provided where there is an identifiable 'giver' and 'receiver' of care, rather than naturally occurring and reciprocal consumer/survivor mutual aid (Fortuna et al, 2022; Davidson et al, 2006; Repper & Carter, 2011). Professional peer support workers uphold the fidelity of peer support, while also honouring the responsibilities of their workplace.

Rather than support being mutually offered, the purpose of professional peer support services is to be of support by mutual agreement, to those engaging with services (Fortuna et al., 2022). As professionals, peer support workers do not engage in friendships with those they support, rather, they build supportive, healing relationships while also maintaining professional boundaries.

Professional peer support workers self-identify as being in a place with their wellness journey where they can focus on the wellbeing of others, holding those they support, their journeys, and/or perspectives with high regard, while also supporting themselves (Davidson et al., 2006; Repper & Carter, 2011).

Although they have personal wellness expertise, and they are identified as the supporter, professional peer support workers are not the 'expert' regarding other people's experiences or wellness journey (Blanch et al., 2012; Repper & Carter, 2011). To mitigate power imbalances, and in keeping with the fidelity of peer support, professional peer support workers understand that every person is the expert of their own experiences, validating and empowering their voice to self-determine their needs, goals, challenges, and barriers.

Independent Peer-Run Organisations

Independent peer-run organisations are uniquely situated. They have the ability to individually determine which practice they would like to adopt. This will also likely be influenced by the source of their funding. Considering funding, the needs of their community and the goals of the service, independent peer-run services will decide which approach to practice they take.

Other Peer-Based Interactions

Where intentional consumer/survivor mutual aid and professional peer support are both guided by the *Guiding Standards of Peer Support*, aligning the practices with values-based peer support, the following interactions are not. These interactions may be of support to those we engage with as they self-determine, and can be shared as an option to support wrap-around care with their community. Once again, the intention of the following differentiation is not to create a hierarchy of supports, but rather identify them as distinctly separate in their guiding principles and general approach.

As people, we often naturally find ways of connecting with one another. Sometimes this includes discussing the challenges, concerns and barriers we live with. Person-to-person conversations can include elements such as advice giving, shame and biases that are not aligned with peer support workers' *Guiding Standards of Peer Support*.

Lived-Experience Engagement & Co-Design

There is immense value in organizations and/or programs meaningfully engaging and co-designing with people who have their own lived/living experiences. Peer support workers may be involved in engagement and co-design, however participating in engagement and co-design **on its own is not peer support as these roles do not provide direct support and they are not led by the *Guiding Standards of Peer Support***.

General Employment of People with Lived-Experience & Social Enterprises

Intentionally hiring people with lived/living experience provides people with an opportunity to engage in an occupation, build skills, and support their financial stability. **Peer support itself is a specific practice that utilizes unique skillsets and expertise aligned with the *Guiding Standards of Peer Support*. This is different from employing people with lived/living experience into other roles.**

Fellowships

Fellowship programs (such as Alcoholics Anonymous) invite people living with addiction and their family members to join people of a common experience in the pursuit of abstinence through designated steps and traditions that they have found to be of support to their community (Alcoholics Anonymous; Narcotics Anonymous; Cocaine Anonymous). Although this is peer-based support, **the designated steps and traditions established in these fellowship programs come from a different support philosophy than peer support workers' *Guiding Standards of Peer Support*.**

Non-Peer Support Worker Facilitated Support Groups & Spaces

Another delivery method that occurs are groups and spaces for group participants to connect peer-to-peer to be of mutual aid, **facilitated by a non-peer worker** such as a social worker or clinician **who does not come from the lens of shared lived experience.** This service delivery model is also utilized in service-supervised informal online chat rooms. The support offered by these groups and spaces is different from the intentional, values-based peer support offered by intentional consumer/survivor mutual aid or professional peer support. The workers may guide conversations, lead interventions, provide therapies, supply resources or offer additional support from the lens of their professional expertise as needed. Although participants within these groups may offer peer-based support, this often comes in the form of unintentional mutual aid.

General Mutual Aid

When people with similar experiences have general conversations to support one another reciprocally this may be categorized as general mutual aid. While these conversations may be of support, **the support offered is different than that of intentional, values-based peer support offered by intentional consumer/survivor mutual aid or professional peer support.**

General Lived-Experience Support

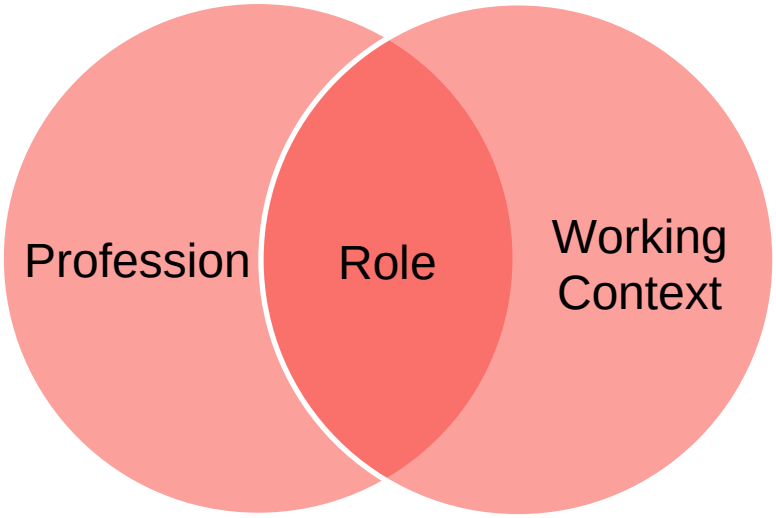
General lived-experience **supporters may intentionally use their lived experience to support others but do so without alignment to the *Guiding Standards of Peer Support*.** This typically happens within the context of organisations.

The Centre for Innovation in Peer Support supports peer staff, supervisors, and organizations from the approach of the ***Guiding Standards of Peer Support*** with a focus on ***Professional Peer Support,*** through training, capacity-building, evaluation, research, knowledge brokerage, and quality improvement.

The remainder of this resource will provide information for further understanding of professional peer support.

PROFESSIONAL PEER SUPPORT PRACTICE

Practice Domains



Peer Support is a ***profession*** that supports a number of ***working contexts***. When the profession of peer support occurs in these different working contexts, it occupies a variety of different ***roles***.

There is recognition that as a profession, peer support can be provided in several systems where the workers have relevant lived experience (Fortuna et al., 2022; Daniels et al., 2010; Blanch et al., 2012). These systems may include, but are not limited to forensic/justice, mental health diversion & court support services, healthcare, emergency services, housing/shelter, employment, immigration, and education/school. Engagement with any of these systems may occur through community social services.

While peer support workers' roles may have different tasks specific to their working contexts, their approach to their role will still be guided by the profession of peer support; that is, the *Values of Peer Support,* demonstrated through the use of values-based actions.

Example

A peer support worker (profession), working in a justice support setting (working context) may use their lived experience and other skills to support people engaging with their service to attend court appointments, coordinate care with a parole officer and discuss the holistic impact of interactions with the justice system (role).

Whereas a peer support worker (profession), working in an employment support setting (working context) would likely not perform the same tasks. They may use their lived experience and other skills to support the person engaging with their service to attend job interviews, coordinate necessary workplace accommodations and discuss the holistic impact of employment challenges (role).

Both peer support workers will have similar approaches, in alignment with the *Guiding Standards of Peer Support*, but their tasks will be different because of their different working contexts.

Professional Peer Support Scope of Practice

A scope of practice is the range of tasks and activities that may be performed by a specific profession. This scope of practice was created by the Centre for Innovation in Peer Support after having reviewed existing scopes of practice of related professions and aligning peer support practice to the *Guiding Standards of Peer Support*.

Peer support is guided by the *Values of Peer Support* (hope & recovery; self-determination; empathetic & equal relationships; dignity, respect & social inclusion; integrity, authenticity & trust; health and wellness, and; lifelong learning and personal growth) (Sunderland et al, 2013). In practice, these values are demonstrated through the use of values-based actions - *Peer Support Values in Action* (Support House: Centre for Innovation in Peer Support, 2018) and *Principles of Practice* (Peer Support Accreditation and Certification Canada, 2016).

The practice of professional peer support is emotional, social and/or practical support (Solomon, 2004; Repper & Carter, 2011; Fortuna et al., 2022) delivered by mutual agreement (Fortuna et al., 2022) by persons who self-identify as living/having lived with similar circumstances and/or challenges (Solomon, 2004; Repper & Carter, 2011; Fortuna et al., 2022). Professional peer support workers have engaged in training and skill development to enhance their ability to support empowering and empathetic relationships with others in their pursuit of self-determined wellness and/or change (Solomon, 2004; Repper & Carter, 2011; Fortuna et al., 2022; Daniels et al., 2010).

Professional peer support is when those with personal lived/living experiences work or volunteer in designated roles in mainstream/traditional services (Fortuna et al., 2022) while "ensur[ing] that the critical aspects of hopefulness, recovery-orientation, empowerment, non-judgmental acceptance, and trust are promoted within the peer support relationship" (Sunderland et al., 2013).

Professional peer support practice can include the following:

- Provision of holistic health and wellness support across sectors that is recovery-oriented, trauma-informed, strengths-based, anti-oppressive, person-directed and mitigates power imbalances
- Provision of compassionate listening and exploration for the purpose of genuinely listening, sharing information, exploring options and choices available, learning from one another and identifying wellness goals
- Compassionately sharing from personal lived/living experiences in a way that meaningfully contributes to the wellbeing of the person engaging with services to support compassionate understanding, inspire hope, provide validation and encouragement, remind the person they are not alone and support their self-exploration
- Participation in the design, development, implementation, promotion, delivery, management, and evaluation, of quality programs and services, which may be done in collaboration with other professionals
- Supporting quality improvement initiatives that include the engagement and/or co-design of people with lived/living experiences
- Provision of learning and growth opportunities to students, volunteers, interns, peer support workers, or other supervisees through supervision, coaching,

mentorship, consultation, training, communities of practice, debrief or other professional learning & development opportunities

- Engagement in meetings, committees and community events (internal and external) for the purpose of professional development, team collaboration and/or coordination of wrap-around care for people engaging with services
- Participation in consultation, collaboration and knowledge brokerage with governments, organizations, institutions, communities, and teams in regard to services, policies and best practices, raise awareness of peer support and advocate for the needs of those with lived/living experiences
- Conducting or participation in research that supports, enhances and advances the practice of peer support
- Any other activities that are in alignment with, and do not conflict with the Values of Peer Support

Practice Conflicts

For authentic peer support to occur the work must be in alignment with the *Guiding Standards of Peer Support*. Examples of common practice conflicts include the following:

Compliance

Compliance may arise as a part of treatment plans, or by direct instruction from officials in the justice system. This may include actions such as medication adherence or program participation. **Participation in peer support services should be completely voluntary**, peer support is meant to be available to those who wish to engage with it. It should not be a program that peers are told they must participate in. **Peer support workers do not encourage or discourage compliance, as their practice is aligned with the value of self-determination.** While the person engaged in services may still be obligated to comply, peer support workers do not steer people towards compliance. Peer support workers should share any legal responsibilities they have to share information with others with the person engaging with services, and may explore potential outcomes of any actions a person is considering taking.

Inhibited Use of Lived Experience

Sharing of similar lived experiences is a pivotal component of the profession of peer support. Organizations will be in direct conflict with peer support practice if there are policies or procedures in place that inhibit the sharing of lived experiences.

Identification of a Peer Support Worker as a Counsellor

Peer support workers are not counsellors. While counselling is an unregulated term in Ontario, it is often associated with psychotherapy techniques, and professional assertions of what a person may be thinking, feeling, or need in order to feel well. Counselling also often comes with follow-up actions the person is directed to explore and report back on. These actions do not support **empathetic and equal relationships or self-determination.**

Professional Judgements

Professional/clinical judgements often occur in assessments and/or in documentation. In peer support practice, assessments should reflect the self-identified needs of the peer, not the “professional judgements” of the peer support worker. **In any assessment where there are professional or clinical judgements, or the supporter re-assesses the**

person's scores, the values of self-determination and empathetic and equal relationships are not honoured, therefore these assessments would not align with peer support. There are assessments where the person engaged with services reflects their current needs. These assessments may be utilized in peer support. Subjective assessments in documentation are always in conflict with the *Values of Peer Support*.

Safety Exception: While peer supporters do not exercise professional/clinical judgements regarding a person's needs, plan of support or areas for growth, peer supporters are able to assess safety concerns. In alignment with other professionals, peer support workers seek to ensure that a person is safe from severe harm to themselves, that they are not at severe risk of causing serious harm to others, and that children under the age of sixteen are not at risk of harm. Whenever possible, peer support workers involve the person engaged with services in the assessment and assurance of safety. Peer support workers should be presented with the same supervision and training opportunities as other professionals to further develop their ability to support safety.

Restraints

When people are experiencing crisis, they may exhibit behaviours that initiate program policies and procedures that require the person be restrained. When a person is restrained the values of **self-determination** and **empathetic and equal relationships** are not honoured and therefore this action conflicts with the *Values of Peer Support*.

Safety Exception: The initiation of restraints does not support the values of **self-determination** and **empathetic and equal relationships.** However, when restraints are absolutely required to ensure the safety of the person, the peer support worker, or others in the space; **and there are not other staff available** to take these actions, a peer support worker may initiate a physical restraint until safety can be assured, in alignment with their organization policies and procedures. **Restraints should only be used after all other de-escalation techniques have been unsuccessful and when there is an imminent safety concern.** Peer support workers should be presented with the same supervision and training opportunities as other professionals to further develop their ability to support safety, serious injury can occur when untrained professionals attempt to restrain others.

Medication Administration & Supervision

Administering, and supervising medication is one of the tasks that may be done by a team. Administering substances by injection or inhalation, including medication is a controlled act under the *Regulated Health Professions Act, 1991.*

A controlled act may be delegated when a regulated health professional who is legally allowed to perform an act decides to delegate the ability to someone else to perform that act, who would otherwise be unable to perform it legally.

Each regulated profession has specific procedures and stipulations about whether acts can be delegated, who they can be delegated to and how they are to be delegated. The colleges of registered healthcare professionals specify that their members ensure the delegatee (the person they are delegating the act to) is able to accept the delegation, that the delegatee possesses the knowledge, skill and judgment to perform the controlled act safely and ethically, and that the delegation is appropriate for the service recipient. It is also important to note that other individuals are not obligated to accept and carry out an act delegated to them, they may reject the delegation.

The Centre for Innovation in Peer Support encourages peer support workers to decline the delegation of controlled acts as they are outside the scope of the role,

expertise and training, creating risk of harm in performing this task; and these acts do not align with the *Values of Peer Support.*

Administering oral medication is not a controlled act, however it is important to note that while peer support workers may be legally allowed to administer oral medication, this action still remains outside the scope of their role.

Administering and/or supervising medication has significant potential to disrupt **Empathetic & Equal Relationships**. These actions are taken from a place of expertise "above" the person engaging with services, rather than an equal relationship that mitigates power imbalances. There is also significant potential to disrupt **Self-Determination**. People engaged in services may not want to take the medication prescribed to them.

Organizations should assess which team members are best suited to administer and supervise any type of medication as this is not the role of a peer support worker.

Safety Exception: Peer support workers trained to administer **Naloxone** may do so in the event of an overdose. Embedded within the legislation is a clause to support people in times of an emergency, such as an overdose. Anyone is allowed to perform a controlled act "**if it is done in the course of, rendering first aid or temporary assistance in an emergency"** (Regulated Health Professions Act, 1991). Therefore, if someone is overdosing any professional or member of the public is permitted to administer Naloxone by injection or inhalation.

This is also an exception regarding the values conflict addressed above. Peer Support Workers are strongly encouraged to become Naloxone trained and have Naloxone available to them in their practice.

Service Philosophy/Approach

When peer support is implemented in organisations with cultures that are **recovery-oriented and person-centred**, peer support workers are best positioned to be able to provided authentic, values-based support.

See **Appendix A** for more information on recovery-oriented practice and person-centred care.

Professional Peer Support Job Description Example

Nature of the Work

The Peer Support Worker is someone who has a similar life experience to/of [INSERT CONTEXT]. They have engaged in special training and skill development to use their experience and other skillsets to enhance their ability to support others. This is a non-clinical role.

Essential Duties

Supporting People Engaging with Services:

- Establish and maintain supportive relationships with people engaging with our services
- Act in accordance with the Guiding Standards of Peer Support (comprised of Mental Health Commission of Canada's *Values of Peer Support,* Centre for Innovation in Peer Support's *Peer Support Values in Action,* Peer Support Canada's *Code of Conduct, Principles of Practice & Core Competencies)*
- Support a person-directed care philosophy
- Share lived/living experiences with people engaged with our services when this is of service to them
- Encourage people engaging with our services and support them in their wellness goals
- Advocate with and, if necessary for, people engaging with our services
- Act as a role model in demonstrating the ways you support yourself
- Provide reassurance and support when there are experiences of crisis or distress
- Support the exploration of choices and options with people engaging with our services
- Support navigation of the health and social services systems, including making referrals to other supports when identified by the people engaging with our services
- Support inbound referrals and intake processes
- [ADD] Any other role specific requirements (Examples: facilitate groups, provide one-to-one support, support court appearances, etc)

Community Partnerships:

- Maintain knowledge on local community resources and learning opportunities
- Foster relationships with community partners
- Promote and facilitate education and awareness of our services

Working as Part of a Team:

- Work collaboratively with team members
- Participate in team meetings, agency events and committees
- Attend regular supervision
- Support program planning, evaluation and reporting

Other Duties

- Complete any administration and documentation tasks
- Abide by all legal requirements as well as agency policy, procedure and practices

Essential Knowledge, Experience & Training

Applicants should have completed a formal peer support training and possess experience related to the practice of peer support. Additional assets may include previous experience as a Peer Supporter in a staff, volunteer, or intern capacity.

Knowledge and Training on the *Guiding Standards of Peer Support:*

- Mental Health Commission of Canada's *Values of Peer Support,*
- Centre for Innovation in Peer Support's *Peer Support Values in Action,*
- Peer Support Canada's *Code of Conduct, Principles of Practice & Core Competencies*

Understanding of Recovery and Wellness

- Proficient knowledge of how to apply Person-Centred and/or Person-Directed Care approaches
- Knowledge and training on trauma-informed care practices
- Knowledge that recovery and wellness are unique and holistic in nature
- Awareness of how to support harm reduction

Self-Awareness

- Awareness and training of how to examine your biases and support in a way that is anti-oppressive and inclusive

Crisis

- Training in supporting people experiencing distress and crisis
- Training in assessing safety
- Knowledge of confidentiality, Duty to Protect and Duty to Report

Other Assets:

- Wellness Recovery Action Plan (Level 1 and 2)
- Brief Action Planning
- First Aid and CPR
- Group Facilitation training
- LivingWorks trainings: SafeTALK, ASIST, Suicide2Hope
- Mental Health First Aid

Essential Skills & Abilities

- Ability to assess how and when to skillfully use selective disclosure (sharing your story)
- Proficient in setting and maintaining boundaries
- Effective conflict resolution skills
- Strong communication skills
- Ability to effectively work as part of a team
- Ability to take initiative
- Ability to be flexible/adaptable
- Ability to engage in reflective practice and seek out ongoing learning
- Excellent problem-solving ability
- Effective time management and organization skills
- Proficient in the use of [INSERT APPLICABLE SOFTWARE]
- Proficient in the use of [INSERT APPLICABLE VIRTUAL PLATFORM(S)]

Relationship to Lived Experience Spectrum

The "Relationship to Lived Experience Spectrum" was created by Ethan Hopkins and Alyssa Gremmen at the Centre for Innovation in Peer Support (2022).

We have relationships with our various lived experiences. Our relationship to these experiences includes how we feel about and understand our journey; and this influences our thoughts, actions, our relationships with others and our relationship to systems. These thoughts, actions and relationships are important in peer support and experience-based advisory work.

The *Relationship to Lived Experience Spectrum* is not a measurement of time, but rather a reflection tool for better understanding the relationship between people and their experiences. Our experiences make up a large amount of our expertise. When we are connected to our experiences, this expertise can lead to supportive relationships with ourselves, others and systems to create positive change. When used ineffectively, we can do harm to ourselves and others and create minimal change.

CONSUMED BY EXPERIENCES	CONNECTED TO EXPERIENCES	REMOVED FROM EXPERIENCES
Sharing Experiences		
• Over-shares from lived experiences • Shares ***Misery Stories*** from a place of misery or anger. Shares for the purpose of receiving support	• Selectively discloses from lived experiences when of benefit to others • Shares ***Resilience Stories*** that focus on impact, learning, actions & supports from their journey in a meaningful way	• Under-shares from lived experiences • Shares ***Glory Stories*** from a place of status or glorification. Unable to meaningfully use their past experiences
Engaging with Others		
• Easily triggered/upset by others' sharing • Focuses on themselves instead of others • Blames/Shames others	• Supports themselves through difficult conversations • Focuses on the wellbeing of others • Holds others with high regard	• Less likely to empathize with others' experiences • Focuses on themselves instead of others • Blames/Shames others
Creating Change		
• Unwilling to collaborate with systems	• Collaborates with systems to bring positive change	• Upholds status quo of systems

Sharing Experiences

CONSUMED BY EXPERIENCES	CONNECTED TO EXPERIENCES	REMOVED FROM EXPERIENCES

Sharing Experiences		
• Over-shares from lived experiences	• Selectively discloses from lived experiences when of benefit to others	• Under-shares from lived experiences
• Shares ***Misery Stories*** from a place of misery or anger. Shares for the purpose of receiving support	• Shares ***Resilience Stories*** that focus on impact, learning, actions & supports from their journey in a meaningful way	• Shares ***Glory Stories*** from a place of status or glorification. Unable to meaningfully use their past experiences

Connected to Experiences

When we are connected to our experiences, we intentionally share parts of our personal lived/living experiences in a way that is meaningful to others. This means we share to support compassionate understanding, inspire hope, provide validation and support exploration of challenges and solutions.

These ***Resilience Stories*** address the pain or struggle of an experience but focus on the impact of our experiences, the learnings we've had, the actions we took and supports we found helpful. Resilience stories are brief, as the interaction is not about us, but rather to be of support to others.

Consumed by Experiences

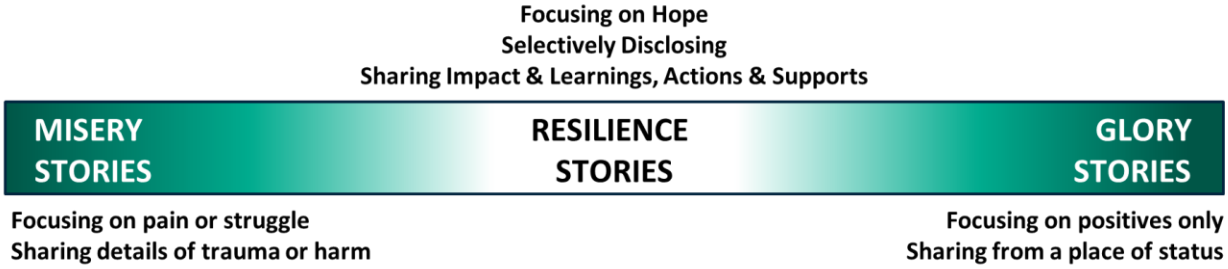
When we are consumed by our experiences we may overshare from our journey, rather than intentionally sharing parts of our journey that are of support to others.

These ***Misery Stories*** focus on pain or struggle. Sharing misery stories means we stay in sorrow and we may overshare details of experiences causing vicarious trauma or re-traumatization for ourselves and others, ultimately causing harm.

Removed from Experiences

When we are removed from our journey, we may be unable to meaningfully use our lived experiences when they could be of support, or share very little.

These ***Glory Stories*** are shared from a place of status or glorification, only focusing on positives, often accompanied by minimal vulnerability. Sharing glory stories creates shame, comparison, and they can be dismissive and prescriptive, ultimately causing harm (I.e., "You just need to work hard").



"The Sharing Spectrum" was created by Ethan Hopkins and Alyssa Gremmen at the Centre for Innovation in Peer Support (2021).

Skillfully Sharing

Trauma & Harm

AVOID: Sharing details about: self-harm actions, suicide plans, violent actions, traumatic event details, drug use rituals, abuse details. Glorifying, comparing or reminiscing on these topics.

DO: Acknowledge the experience then discuss impacts, learnings etc. and then openly share about feelings, meanings, thoughts, impacts, learning etc.

Example: "I used to self-harm too, it helped me cope with things and gave me a sense of control, something I felt I had very little of at the time. I learned new coping strategies and slowly I was able to stop self-harming."

Medication

AVOID: Sharing about specifics (dosages, names etc.), medical advice, encouraging or discouraging medications.

DO: Remain neutral, medications are part of some people's journey and work well, they may have side effects and journeys with medication are personal. We can support people to bring questions to their doctors should they want to know more about medication.

Example: "Medication and the process of finding the medications that work or don't work is personal, it's about finding the best fit for you. I know for some people medication has been part of their journey and for others it has not. You have the right to be curious and ask questions about your medication process if you would like to."

Service Providers

AVOID: Sharing about specific positive or negative experiences with specific service providers, Encouraging or discouraging a service.

DO: Remain neutral. Experiences with services are personal. We can support people to explore options open to them, and explore the different offerings of a service. Be sure to support their self-determination and honour the experiences people have with different providers. We can support people to share their needs, their gratitude and their concerns with services they interact with.

Example: I have had both positive and negative experiences with services, sometimes you find a great fit, and sometimes it does not feel great. The experience with services is personal. If it fits for you that's great, if it does not seem to fit there are options for services we can explore.

Engaging with Others

CONSUMED BY EXPERIENCES	CONNECTED TO EXPERIENCES	REMOVED FROM EXPERIENCES

Engaging with Others		
• Easily triggered/upset by others' sharing • Focuses on themselves instead of others • Blames/Shames others	• Supports themselves through difficult conversations • Focuses on the wellbeing of others • Holds others with high regard	• Less likely to empathize with others' experiences • Focuses on themselves instead of others • Blames/Shames others

Connected to Experiences

When we are connected to our experiences, we are at a place with our journey that we can support ourselves through conversations with others that include difficult or triggering topics for us. While supporting ourselves, we are able to focus on the wellbeing of others. We are also able to hold others, and their journeys and/or perspectives with high regard.

Consumed by Experiences

When we are consumed by our experiences we can become easily triggered/upset by others' sharing when it touches on topics that intersect with our journey or topics, we find difficult to support ourselves through in general. We may have challenges focusing on the wellbeing of others. We may also shame or blame others, whether that is others sharing their journey and/or perspective with us or shaming and/or blaming professions that we interacted with along our journey.

Removed from Experiences

When we are removed from our journey, we may be less likely to empathize with others' experiences. No longer able to truly empathize, we may have challenges focusing on the wellbeing of others. We may also shame or blame others, removed from the day-to-day impacts of challenges we once faced we may be impatient and unempathetic towards others' challenges.

Creating Change

CONSUMED BY EXPERIENCES	CONNECTED TO EXPERIENCES	REMOVED FROM EXPERIENCES

Creating Change		
• Unwilling to collaborate with systems	• Collaborates with systems to bring positive change	• Upholds status quo of systems

Connected to Experiences

When we are connected to our experiences, we are able to collaborate with governments, organizations, institutions, communities, and teams. Conversations with these groups may include service offerings, policies and best practices, raising awareness of peer support and advocating for the needs of those with lived/living experiences in a way that is professional, assertive, and respectful in order to bring positive change.

Consumed by Experiences

When we are consumed by our experiences we may be unwilling or unable to professionally, assertively, and respectfully collaborate with systems. We may find that the harm we have experienced within systems is still actively causing us distress, leaving us unable to hear others' perspectives and/or work together.

Removed from Experiences

When we are removed from our journey, we may uphold the status quo of systems. We may find that we rarely advocate for meaningful change and may disregard calls from others to create change.

Empathetic Communication

Preface

Empathy

A common reflection is that… "empathy is standing in someone else's shoes, seeing the world through their eyes, and feeling what they're feeling." (Parkin, 2015; TEDxTalks, 2015).

Paul Parkin, an adjunct professor at Utah Valley University wrote his dissertation on empathy and communication and he suggests that:

a. that's not possible;
b. and when we think we can do that, we actually start making assumptions about what other people have experienced, assumptions that can lead to disconnection, or misunderstandings (TEDxTalks, 2015).

It's important that we recognize we have never had the exact same experience as someone else, we have never been in the exact same shoes as another person.

Example

Consider two people moving homes. While we may say we have "had the same experience" that isn't quite true.

One of us may have had help moving, while the other did not. Maybe it was raining the day one of us moved and sunny for the other. Our moving boxes would not have been the same weight and we would have been moving from and to different homes with different features. One of us may have more experience with moving and feel more confident and comfortable throughout the process.

This is a basic example. In practice we would also consider aspects of ourselves such as social location, experiences with trauma, and more.

Understanding that our lives and experiences are different is embedded within the *Guiding Standards of Peer Support*, as one of the *Peer Support Values in Action* are, "The peer support worker reminds me that my health and wellness is unique to me" (Support House: Centre for Innovation in Peer Support, 2018).

So, then what is Empathy?

If we can't stand in someone else's shoes, then what is empathy?

"**Empathy is the is the righteous struggle to try, to try to understand what it's like to be in their shoes**, to try to understand what they're feeling; and that's a process that happens through communication … **empathy forges communication that is inquisitive, non-judgemental, validating and compassionate**" (Parkin, 2015; TEDxTalks, 2015).

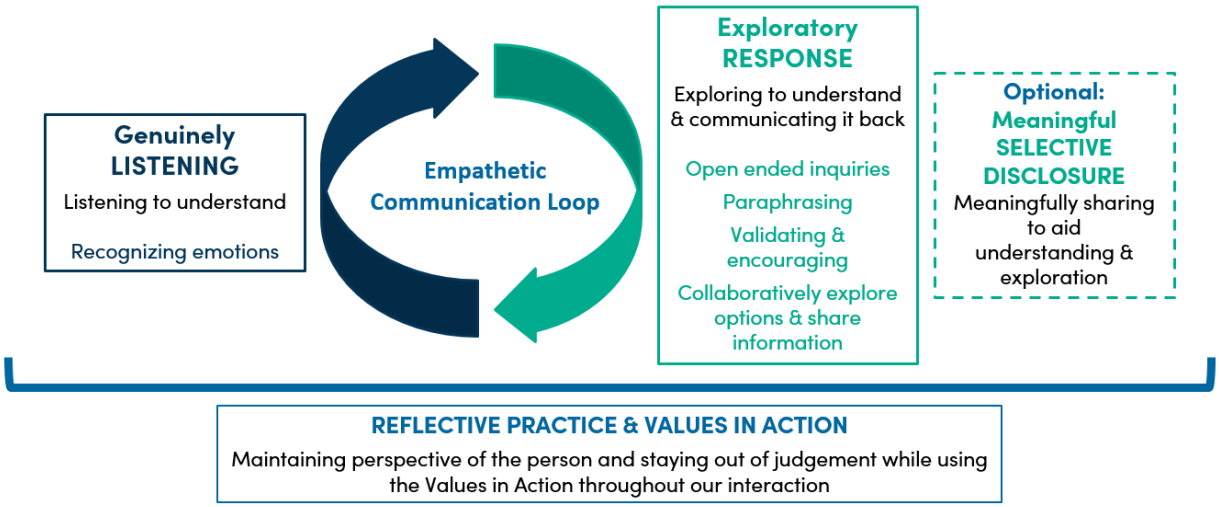
Paul Parkin's work is in very close alignment with earlier work done by Teresa Wiseman, a nursing scholar who published a concept analysis which concluded that there are four qualities of empathy; **perspective taking, staying out of judgement**, **recognising emotion in other people**, and then **communicating** that recognition (Wiseman, 1996; Brené Brown on Empathy, 2017).

Empathetic Communication Model

The “Empathetic Communication Model” was created by Alyssa Gremmen & Ethan Hopkins at the Centre for Innovation in Peer Support (2022).

The Centre for Innovation in Peer Support created the *Empathetic Communication Model* to illustrate how empathy, and *Values in Action* are present and intertwined in the delivery of peer support.

Peer support workers approach their work with compassion; concern for the wellbeing of others and a desire to be of support (Singer & Klimecki, 2014). This compassion drives our desire to utilize empathy and the *Peer Support Values in Action* through genuinely listening, exploratory response, meaningful selective disclosure, and reflective practice. Throughout our connections we continuously listen and collaboratively explore to be of support.



The **Empathetic Communication Model** is a loop. You will engage with the different parts of this model multiple times, continuously throughout every interaction. Every time a peer supporter offers an exploratory response, it is important to do so with the intention of listening again.

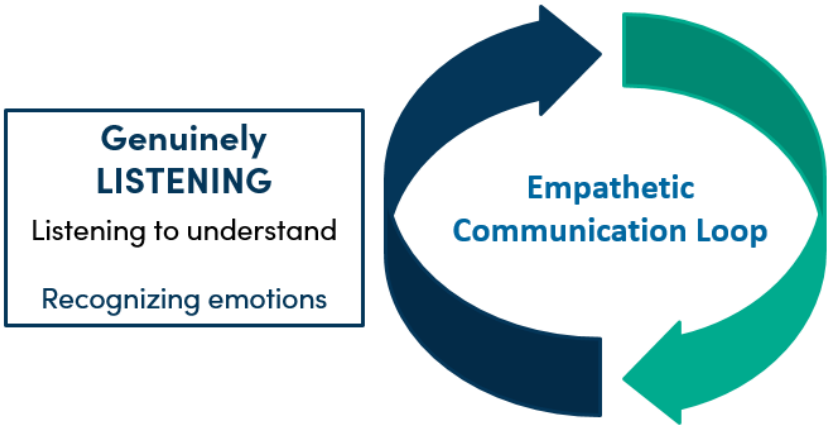
Reflective Practice and Values in Action

Engaging in regular self-reflection before, during and after interactions is a practice that enhances our support through continuous learning and personal growth. All throughout the interaction, we are **reflecting** on what is being shared, then aligning our actions to the **Values in Action**. This allows us to **maintain the perspective of the person** and **stay out of judgement**, two qualities of empathy.

To take the perspective of those we support it is required that we be **non-judgmental** and meet people where they are at in their journey in that moment. As supporters we must check our biases and remember that everyone’s journey, **health and wellness is unique to them** and it is vital that we **do not express disapproval of people or the choices they make**.

Genuinely Listening

The goal of genuinely listening is to create space where we can truly **understand the person we are supporting**; their unique life context, needs, barriers, challenges, concerns, strengths, and goals. It is important that we remain curious to their perspectives and how they understand their lived and living experiences. While listening, we **recognize the emotions** of others as the impact to that person and what is true for them. This will help us determine how we can respond supportively.



While this may seem like a less significant part of our communication, it is actually the most crucial and important part of the model. Without listening to understand, we may risk a conversation deviating away from a person's needs.

Values in Action: Genuinely Listening

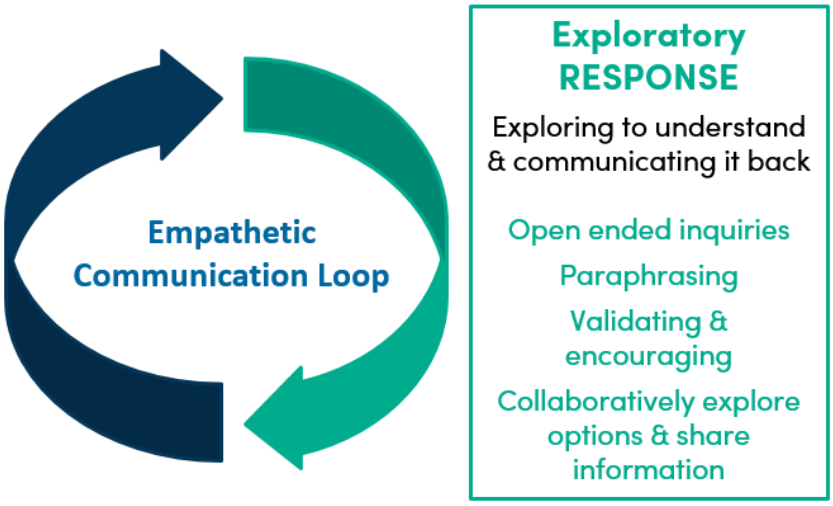
The peer support worker genuinely listens to me.

The peer support worker does not express disapproval of me or the choices I make.

Exploratory Response

The goal of exploratory **response** is to further explore in order to better understand a person's unique life context, needs, barriers, challenges, concerns, strengths, and goals; and communicate our understanding back to the person we are supporting, checking in to see if we understand correctly. This ensures that we provide support that is meaningful to them.

There are many ways we can engage in exploratory responses. Consistent with everyone's journey, health and wellness being unique to them, the **supports that are of benefit to someone will also be unique to them**. At different times and points in the conversation, we may choose to offer any of the options below when they are applicable. Once we have offered an exploratory response, we then return to genuinely listening.



Exploratory responses include:

Open-ended Inquiries/Questions

We can empathetically **explore their perspective and experiences** through the use of open-ended inquiries/questions. This **inquisitive** space not only supports our understanding but also creates a space for the other person to self-explore, and self-determine what is important to them, and what their needs and wants are.

Validating and Encouraging

As peer support workers, we **do not express disapproval of people or the choices they make,** we seek to be validating and encouraging in our response. We may validate the thoughts, emotions, and experiences of the person. This creates safety, while inviting the person to share more about their life with us.

Collaboratively Exploring Options and Sharing Information

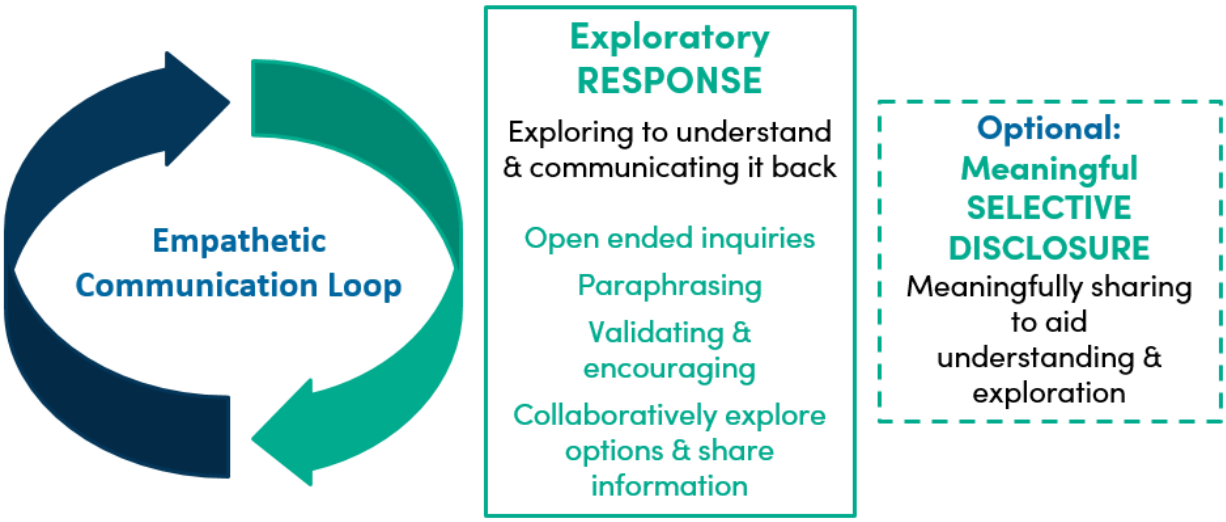
For those who wish to explore further supports we can **collaboratively explore options open to the person when they have a decision to make**. This can include creating goals, **sharing information and resources with the person,** further exploring the impact of experiences, and/or brainstorming next steps. It is important that options, goals, resources, and next steps are directed by the person rather than ourselves.

Communicating Back

Communicating back our understanding of what has been shared often involves **summarizing, and paraphrasing** what we have heard and understood**.** This is also an opportunity to ask if we have understood correctly, providing the person we are supporting with the opportunity to either affirm our understanding or clarify.

Exploratory Response: [Optional] Meaningful Selective Disclosure

Throughout our interactions we may **tell those we support about our experiences in a way that is meaningful to them.** Meaningful selective disclosure is when we share from our personal lived experiences in support of exploratory response. The purpose of sharing from our journey is to aid in the other person's self-determined exploration, not to direct people to take steps, or support themselves the same way that we have.



Meaningful selective disclosure requires us to reflect on points of connection between our experience and the experience of others. Even with differences in our journeys, we can look within ourselves and seek points of connection with emotions, impacts, and experiences of others as similar to our own.

Sharing our experiences in a way that is meaningful to the person can **convey that people are not alone in their experiences and struggles**, inspire hope, provide **validation**, and aid in their exploration of choices and options available to them, including **sharing the ways that we take care of ourselves**.

We share meaningfully using *Resilience Stories.* This way of sharing from our journey addresses the pain or struggle of an experience but focuses on the impact of our experiences, the learnings we've had, the actions we took and supports we found helpful. Resilience stories are brief, as the interaction is not about us, but rather to be of support to others.

We can engage in exploratory response without selective disclosure, but we avoid disclosing/sharing without having the purpose of **conveying that people are not alone in their experiences and struggles**, inspiring hope, providing **validation**, and/or aiding in their exploration of choices and options available to them. If the conversation becomes about our journey and experiences instead of being in service of the other person's experience we have shifted away from a supportive interaction. Skillfully and mindfully sharing from our journey requires practice, and training may be helpful.

Values in Action: Exploratory Response

The peer support worker genuinely listens to me.

The peer support worker reminds me that my health and wellness is unique to me.

The peer support worker gives me encouragement.

The peer support worker shares information with me, e.g., community resources that are available, different learning opportunities.

The peer support worker helps me explore options open to me when I have a decision to make.

The peer support worker does not express disapproval of me or the choices I make.

The peer support worker tells me they believe in me.

The peer support worker tells me my feelings and opinions are worthwhile.

The peer support worker follows through on commitments they make.

The peer support worker tells me that I am not alone in my experiences and struggles.

The peer support worker encourages me to do things for myself instead of doing things for me.

The peer support worker reminds me that I have the right to express my needs.

The peer support worker tells me about their experience in a way that is meaningful to me.

The peer support worker tells me that I am not alone in my experiences and struggles.

The peer support worker demonstrates ways they take care of themselves.

Peer Support Documentation Guidelines

Information within the documented records kept about someone's care ultimately belongs to the person engaging with a service. Documentation is a communication tool. When done in a way that is supportive and person-directed, documentation can be used to inform a circle of care of the goals, needs and preferences of a person engaging with services.

Peer Supporters can document in alignment with the Values of Peer Support to support a person's journey.

These guidelines highlight the unique considerations of documentation for Peer Supporters. Each organization will still need to reference their own policies and procedures to ensure safe practices. However, these guidelines may support advocacy and discussion regarding any changes to current practice.

Discussing Documentation

- **Presentation is key.** If you, as a supporter present documentation as inherently negative, that will impact the person and their feelings towards documentation. Share that it is a communication tool and that it is there to be of support to them.
- **Ensure the Person Engaging in Services is fully informed** about documentation including:
  - Their rights
  - Boundaries of confidentiality
  - What information is gathered and for what purpose
  - Who information is shared with
- **Revisit these conversations** throughout your relationship and be open to further discussion whenever it may be needed. Provide room for dialogue and questions.

What Do We Document?

- Anything relevant to the person's care
- Referrals to programs and services
- Any decisions made about a person's care, and why
- A person's goals, needs and barriers
- Attendance or participation
- When a person declines service
- Service concerns
- Serious Occurrences/Significant Events – *Please see your internal policies and procedures*

See Appendix B for a Documentation Template Example

How We Document

Anything Documented Should Be:

- **Within Scope** - Our documentation is focused on the scope of practice of a Peer Supporter; our alignment with the values through the Peer Support Values in Action, rather than clinical judgements. (See documentation template example).
- **Intentional** – Information in our documentation is recorded with reason and is relevant to the person's care. Do not write a detailed transcript of everything that is said and done in an interaction. Do include specific information about what you did as a support (I.e., Which part of a wellness plan you discussed, what harm reduction strategy were shared, which *Values in Action* were used, etc.) Refer back to "*What We Document*" section.
- **Person-Directed** – Reflect the perspective of the person engaging with service.
- **Strengths-Based** – Highlight a person's strengths, and what they are doing to support their wellness. (I.e., 'Marshall shared that he met his goal of attending his first counselling appointment yesterday' instead of writing 'Marshall was compliant with treatment yesterday').
- **Collaborative** - Peer Supporter's should make every effort to engage in collaborative note taking. This means the notes are created by both Peer Supporter and person engaging with services working together to decide what is documented.
- **Objective** - When documenting we are mindful of the language we use and remain objective in our descriptions of the interaction.
    - Notes should not include subjective assumptions, judgements or conclusions. Support any decisions you make with objective evidence and facts (I.e., Vlad shared he is injecting heroin. I provided a safer injection pamphlet which included safer injection practices).
    - Detail things as they occurred (I.e., Sandy stood up and walked out of the meeting without saying anything, Sandy then walked out of the building and got into her vehicle).
    - When recording a quote of what someone has said record it as said, using quotations (I.e., Omar stated, "I have felt sad for three days.")
- **Individualized** – Avoid documenting the names of people not directly in the client's circle of care (I.e., neighbour or another person engaged with services). Some common practices include using "Neighbour", "Other resident" or "Resident 2" when referring to others. When writing a direct quote use block parenthesize if the person uses someone's name outside their circle of care (I.e., "Bob upset me." becomes "[The neighbour] upset me").
- **Timely** – Notes should be recorded as soon as possible. Ideally, done collaboratively at the end of an interaction.
- **Clear** – Use clear, accessible language. Do not use acronyms without clarification. Always proofread for accuracy, spelling and grammar.

RESOURCE HIGHLIGHT:

COMPASSIONATE LANGUAGE FOR MENTAL HEALTH AND SUBSTANCE USE: HOLDING PEOPLE IN HIGH REGARD

APPENDIX

Appendix A – Recovery-Oriented Practice & Person-Centred Care

Recovery-Oriented Practice

"In several pilot studies of peer workers, it has been reported that they are less likely to be successful or effective in teams that are not already working in a recovery-focused manner and not committed to engaging with peers as team members. Therefore, it is strongly recommended that teams in which peer workers are placed have already accessed training in recovery-focused practice and have a commitment to making the service more recovery-focused" (Repper et al., 2013).

"The actions, choices, and behaviours of anyone providing mental health and substance use services or supports can have a significant impact on service users and how they experience care. Everyone deserves respect, dignity, and the opportunity to live a life consistent with their hopes, goals, and aspirations. These are our collective human rights. Recovery-oriented practice instils hope, and empowers and sustains the recovery journey by building upon people's strengths, passions, and purposes" (Mental Health Commission of Canada, 2021).

What is Recovery?

"Recovery in mental health and substance use is about people living satisfying, hopeful lives and contributing to society even if they experience ongoing symptoms of a mental health problem or illness. It looks different for everyone, so people should be empowered to decide what recovery means for them and what they need to achieve it" (Mental Health Commission of Canada, 2021).

Dimensions of Recovery-Oriented Practice

The Mental Health Commission of Canada outlined dimensions of recovery-oriented practice in their *Recovery-Oriented Practice: An Implementation Toolkit (2021):*

Dimension 1: Creating a culture and language of hope

Including **hopeful language in all organisational policies and practices** helps create a mental health system foundation that is geared toward fostering recovery.

Dimension 2: Recovery is personal

Recovery-oriented practice recognizes **every person's uniqueness and right to determine their own path to mental health and wellbeing**. It supports people's individual journeys to wellness and helps them lead satisfying and purposeful lives in their communities of choice. **Healthcare workers put people at the centre of mental health and substance use practice and partner with them to build on their strengths and foster autonomy.**

Dimension 3: Recovery occurs in the context of one's life

Fostering recovery requires **understanding people in the context of their lives**. Family, friends, neighbors, local community, schools, workplaces, and spiritual and cultural communities all influence mental health and well-being and can play an important role in supporting recovery.

Dimension 4: Responding to diverse needs of everyone living in Canada

Recovery-oriented practice is grounded in principles that encourage and enable **respect for diversity and that are consistent with culturally responsive, safe, and competent practices**. It appreciates the rich diversity of Canada's population to better **respect the choices people make in their recovery processes and determine how best to adapt services to meet their needs**.

Dimension 5: Working with First Nations, Inuit, and Métis

Many principles grounded in Indigenous knowledge and cultures — such as promoting self-determination and dignity, adopting a holistic and strengths-based approach, fostering hope and purpose, and sustaining meaningful relationships — also form the foundation of a recovery orientation. **Recovery oriented practitioners recognize the distinct cultures, rights, and circumstances of First Nations, Inuit, and Métis, and understand how recovery for Indigenous people is uniquely shaped by Canada's history of colonization.**

Dimension 6: Recovery is about transforming services and systems

Achieving a fully integrated recovery-oriented mental health and substance use system is an ongoing process that will take time to implement. Recovery is a journey not only for people living with mental health problems or illnesses and/or substance use (and their families), but for everyone involved in providing supports and services. **Commitment to recovery needs to be embedded into everything an organisation does, including instilling the skills and resources for recovery-oriented practice in its workforce.**

Click here to see Mental Health Commission of Canada's *Recovery-Oriented Practice: An Implementation Toolkit (2021)*

Person-Centred Care

Source: (Kirschenbaum, 2021)

Carl Rogers, was a professor of psychology that throughout his life worked at the University of Ohio, Chicago & Wisconsin. He and his colleagues created the Client-Centered approach in their book, *Client-Centered Therapy* (1951). Later in his career, Rogers and his colleagues at Center for Studies of the Person began increasingly using person-centered to describe their work.

"Rogers argued and demonstrated that the client has within himself the ability and tendency to understand his needs and problems, to gain insight, to reorganize his personality, and to take constructive action. What clients need, said Rogers, is not the judgment, interpretation, advice or direction of experts, but supportive counselors and therapists to help them rediscover and trust their own inner experience, achieve their own insights, and set their own direction"

In Rogers' work he clarified that it was the therapeutic relationship that was of most support to increasing peoples' wellness. He established three "core conditions" of the client/person-centered approach:

1. "To accept the client as he or she is, as a person of inherent worth possessing both positive and negative feelings and impulses. Rogers adopted a term from his student Standal (1954) and called this acceptance and prizing of the person 'unconditional positive regard'"
2. "Empathy – 'the therapist's willingness and sensitive ability to understand the client's thoughts, feelings and struggles from the client's point of view…to adopt his frame of reference' (Rogers, 1949, p. 84.)"
3. "Congruence - to be genuine, real, authentic, or congruent in the relationship."

Today, this approach may be characterized by:

- "A belief in the client's 'self-actualizing tendency,' that is, an innate motivation to grow and mature and realize its self-interest, especially when provided with a supportive environment."

- "A reliance on the therapeutic relationship, characterized by the core conditions of congruence, empathy and unconditional positive regard, for therapeutic progress"
- "A continuing focus on the client's inner experience, hence…"
- "An absence of directive techniques or perspectives introduced by the therapist, such as questions, interpretation, advice, coaching, and the like (except for relatively rare expressions of counselor congruence)"
- "An avoidance of diagnosis, treatment plans and other therapist-centered methods that reflect the medical model of mental illness"
- "A view of the client as a whole person in process of 'becoming,' that is, becoming a more fully-functioning person; therefore, counseling focuses not simply on a presenting problem but on more holistic change, so the client can continue to grow and exercise self-direction beyond the therapeutic relationship."

Comparison of a Person-Centred and Illness-Centred Approach

An illness-centred approach focuses on establishing an illness assessment and determining what services or treatment would be effective in the reduction or removal of symptoms.

Mark Ragins is a recovery-based psychiatrist who champions person-centered care in his practice. He compared some of the core differences between the person-centred approach and an illness-centred approach (sometimes referred to as "the medical model").

Person-Centred	Illness-Centred
The relationship is the foundation	The diagnosis is the foundation
Begin with welcoming – outreach and engagement	Begin with illness assessment
Services are based on personal experiences and help needed	Services are based on diagnosis and treatment needed
Services work towards quality-of-life goals	Services work towards illness reduction goals
Treatment and rehabilitation are goal driven	Treatment is symptom driven and rehabilitation is disability driven
Personal recovery is central from beginning to end	Recovery from illness sometimes results after the illness and then the disability is taken care of
Track personal progress towards recovery	Track illness progress toward symptom reduction and cure
Use techniques that promote personal growth and self-responsibility	Use techniques that promote illness controlled and reduction of risk of damage form the illness
Services end when the person manages their own life and attains meaningful roles	Services end when the illness is cured

This chart is adapted from: (Ragins)

Appendix B – Documentation Template Example

Date of Service:	**Person Engaged with Service:**	**Supporter:**
Location of Service (phone, email, in-person location):	**Collaboratively Documented:** ☐ Yes ☐ No	**Service Delivery:** ☐ One-to-One ☐ Group
Intention of Service - What did the person want to get out of the meeting?		
Conversation:		
Support Provided – What *Values in Action* were utilized?		
Response to Service Provided - Did the person get what they were looking for out of the meeting?		
Plans for Follow Up:		

ADDITIONAL RESOURCES TO EXPLORE

Centre for Innovation in Peer Support's

Provincial Systems Virtual Learning Centre & Resource Hub

for Peer Supporters & Organizations

Support House's Centre for Innovation in Peer Support's full programming is offered through our Virtual Learning Centre & Resource Hub which supports the most current, best practices in Peer Support.

Through our Virtual Learning Centre, we offer trainings, consultation, our Peer Professional Development Webinar Series, and provincial communities of practice. Our Resource Hub is home to our educational toolkits, documents and videos. These offerings support the practice and implementation of Peer Support within Ontario.

Products on our Resource Hub:

- ***Guiding Standards of Peer Support*** (from Mental Health Commission of Canada, Peer Support Canada & Centre for Innovation in Peer Support)
- ***The History of Mental Health & Addiction Peer Support: A Canadian Context***
- ***Peer Support Implementation Toolkit***
- ***Peer Staff Job Description***
- ***Peer Support Hiring Guide***
- ***Peer Support Documentation Guidelines***
- ***Empathetic Communication Toolkit***
- ***Peer Support & Ontario Program Standards***

CLICK HERE TO VISIT OUR VIRTUAL LEARNING CENTRE & RESOURCE HUB

CLICK HERE TO VISIT OUR YOUTUBE CHANNEL

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