Drift from Peer Support Values and Standards:

A Position Statement and Call for Action

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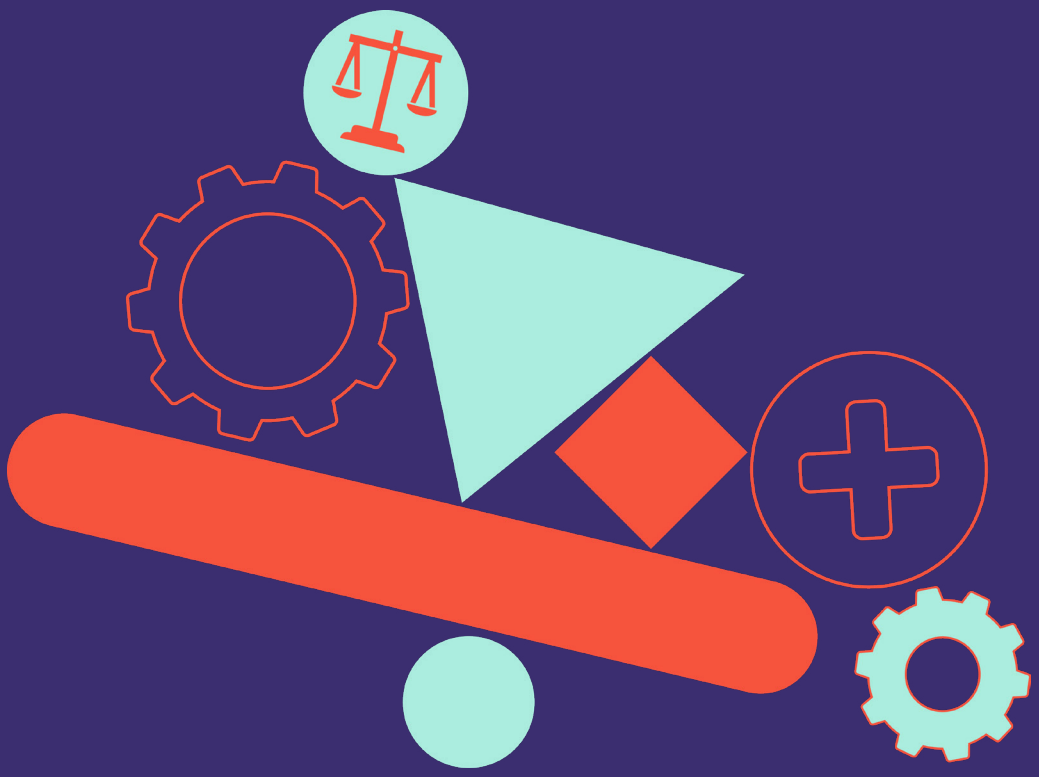

Position Statement of the
PeerWorks Board of Directors

PeerWorks

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Foreword

As Operations Director of PeerWorks, I am pleased to share "Drift from Peer Support Values and Standards: A Position Statement and Call for Action." The collaboration and soul-searching conversations within our vibrant community and collective effort to identify and address shared experiences of concern have made this document possible. Witnessing the passion of the many individuals who have contributed their insights and wisdom to this endeavour has been incredibly inspiring.

At the core of this statement lies a commitment to preserving the authenticity and integrity of Peer Support, amidst the ever-evolving landscape of mental health and addictions services. The statement is a testament to the Peer Support community's unwavering belief in Peer Support and the transformative power of peer connection, empathy, and shared lived experiences.

I hope this document will inspire both government action and collective advocacy in and for our Peer Support community. Together, we must prioritize working towards equitable funding for Consumer/Survivor Initiatives, Peer-led Programs, and Peer Support Organizations. We must develop more robust policies to support the values-aligned integration of peer supporters into health systems and continue protecting and promoting the independence and influence of peer-led initiatives.

I extend my deepest gratitude to all who have contributed their time, energy, and dedication to developing this statement. Your voices have shaped the articulation and mobilization of this call for shared understanding and collaborative action. I especially want to thank Lee de Bie, whose hard work and commitment made this all possible, and Emily Michetti-Wilson for her thoughtful, creative, and critical support.

Let us continue championing Peer Support values and work towards a world where lived experience is valued, peer autonomy and peer culture are protected, diversity is respected, and peer support is available to all.

Allyson Theodorou

PeerWorks Operations Director

Acknowledgements

We extend our deep appreciation to members of the peer support community who participated in the advisory committee, survey, and focus group consultations that informed the development of this position statement. Thanks also to those who strengthened the statement and recommendations through the provision of oral and/or written comments on earlier drafts. We would especially like to acknowledge the following individuals for their feedback and support:

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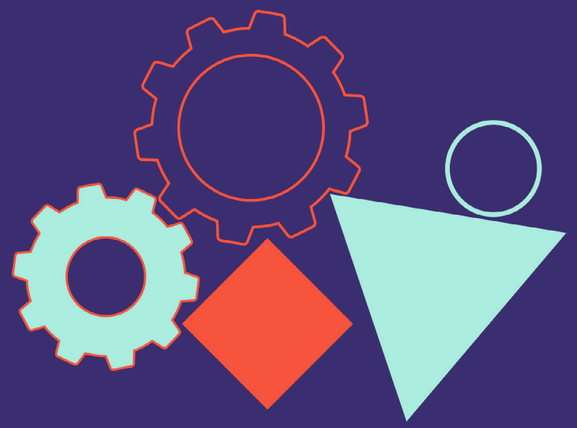
Executive Summary

This Executive Summary describes the background, purpose, and focus of the position statement. It then gives an overview of the ten key points of the position, which have been developed over 18 months through consultation with more than 75 people.



Background

Peer support is an effective and valuable form of support that has been increasingly integrated into mainstream mental health and addiction services over the last two decades (Forchuk et al., 2019; Peer Support Canada, 2022; Sunderland & Mishkin, 2013).

These integration efforts have been contentious in the consumer/survivor movement. As a community we have faced the dilemma of "remain[ing] small…and autonomous, thus limiting [our] help to a smaller ring of persons, or to accept government funding, at the risk of co-optation, in an effort to reach larger numbers of those in need" (McLean, 2000, p. 839). For over half a century we have discussed and debated whether and how to partner with non-peer service providers and organizations (Usar, 2014).

While many believe that integration and collaboration have important benefits for the purposes of better recognition of peer support, funding security, job opportunities, equitable pay, choice of service options for people seeking support, and improvement of the mental health system, others fear the costs and consequences of assimilation (Rebeiro Gruhl et al., 2016, 2023; Standing Senate Committee on Social Affairs, Science and Technology, 2006).

Over the last decade, we have observed troubling trends in how peer support in the mental health and addiction sector is understood, funded, organized, and practiced. Some peer support initiatives have remained self-governed and adequately resourced and supported to maintain fidelity with peer support values. Others have not. In some contexts, peer support has been quite successful in shifting the dominant values of the mental health system (Fisher, 1994). In others, the system has done more to shift the values and role of peer supporters.

We worry that in the process of expanding access to peer support in mainstream mental health and addiction services, we are losing our politicized roots in social movement histories and inadvertently reinforcing — rather than reforming — the power (and potential harm) of the psychiatric system. We are concerned that we may be enacting the very same practices that the consumer/survivor and drug user movements worked so hard to oppose a generation ago.

> **"Employing peer support workers might have started as a well-intentioned way of addressing the culture of mental health services and responding to the voices of people who were using them. But their roles have included many of the duties that make mental health services oppressive."**
>
> (Watson, 2020, p. 241)

In this position statement, we examine this worrisome situation of peer support drift, which is the deviation of peer support practices away from peer support values and standards.

Purpose of the Position Statement

A position statement is composed of persuasive arguments that outline an organization's stance on an issue, often with the goal of raising awareness and proposing solutions. PeerWorks offers this position statement with urgency, in a spirit of concern, shared learning, and support. Consistent with PeerWorks' (2023a) mission to "strengthen and promote diverse peer voices in Ontario, through community building, information-sharing, collaboration, advocacy, and education," the statement has been developed to raise awareness of the problem of peer support drift.

Our overall hope in creating this statement is to ensure that peer support is delivered with integrity to maximize its beneficial impact on individuals and the healthcare system (Gillard et al., 2017). By contributing to articulations of how peer support should and should not be practiced, we also seek to strengthen peer-led definitions and to prevent external imposition of standards (Penney & Prescott, 2016).

Focus of the Position Statement

While drift can occur in any peer support setting, this position statement is focused on understanding and addressing drift that impacts frontline peer support roles in mainstream mental health and addiction services.

This statement of PeerWorks' position on peer support drift is not designed as a practice standard or practical tool. However, it is written to align with existing peer support standards (Peer Support Certification and Accreditation Canada, 2016; Sunderland & Mishkin, 2013; Support House: Centre for Innovation in Peer Support, 2022) and is meant to be used in combination with them to support collective advocacy. Throughout, we refer readers interested in the practical application of this material to other toolkits and guidance documents more suited to this aim.

Overview of the Position

PeerWorks' position on peer support drift is articulated in ten statements, divided into three parts, which are summarized below. Peer support will continue to evolve, and we expect this living document will also require revision over time.

Part 1: The Importance of Protecting the History, Values, and Role of Peer Support (statements 1–3)

1. Peer support is — and must remain — rooted in social movement histories and values.

   This statement defines both informal, naturally occurring peer support and formalized, structured peer support in the mental health and addiction sector and grounds both in social movement histories and values. We advocate that these values should remain central throughout contemporary peer support practice.

2. The peer support role is unique, and this uniqueness is valuable and must be protected.

   Peer support is a unique approach that significantly differs from the practice of other health professions. This section describes the important special features of peer support that need to be protected and differentiates these from the activities of other regulated health professions.

3. Preserving the term "peer support" and the variety of approaches to peer support help to protect its unique role and contribution.

   One way to protect the uniqueness of peer support is to ensure the use of the term "peer support" consistently refers to practices that align with peer support values and standards. We must also preserve the unique approaches to peer support practiced in independent peer-led initiatives that are harder to maintain within mainstream settings.

Part 2:
Current Challenges in Protecting the Integrity of Peer Support (statements 4–9)

The following six statements discuss the causes, characteristics, and consequences of peer support drift, as illustrated in Figure 1.[1]

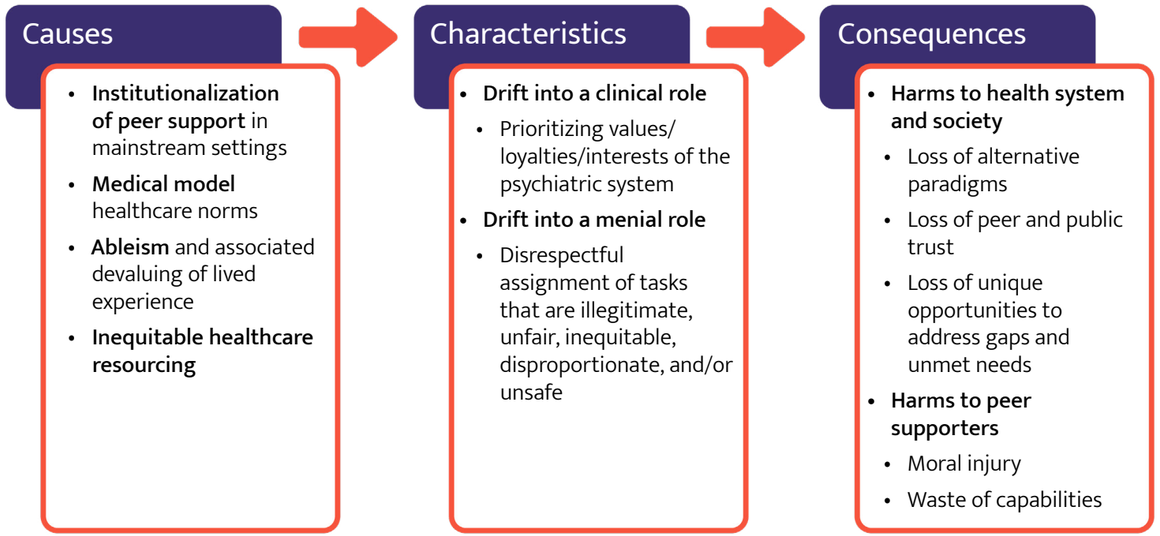


Figure 1. Causes, Characteristics, and Consequences of Peer Support Drift

4. Institutionalization into mainstream health systems is contributing to the depoliticization of peer support.

   Many social movements get mainstreamed over time. This section describes how institutionalization has affected the practice of peer support, causing a loss of independent peer voice, a move from social movement to service delivery models, and a weakening of advocacy.

5. Peer support practice is drifting from its core values and special role.

   Peer support drift refers to a deviation in peer support practices away from peer support values and standards. This section illustrates the spectrum of peer support from ideal conditions and practice to drifted and non-peer practices.

6. Peer support drift occurs at the level of individuals, organizations, and systems, and tends to take two forms: drift into clinical and menial work.

   Peer support drift is systemic and must be addressed at the level of organizations and health systems. Working conditions can push peer supporters to drift, so we also need strategies to support them in protecting the peer support role. This section describes how drift into clinical approaches and menial work maintains the power hierarchies of the health system rather than disrupting and transforming the system with peer support values.

7. Peer support drift is a political, legal, and ethical problem.

   This section elaborates why peer support drift is troubling by explaining how it is a political, legal, and ethical problem. By understanding the nature of the problem, we can better identify ways to navigate and address it.

8. Peer support drift causes harm to health systems, society, and peer supporters.

   Peer support drift causes a series of social harms, including loss of alternative paradigms, loss of peer and public trust, and loss of unique opportunities to bridge gaps in the health system, address unmet needs, and achieve the valued benefits of peer support. Drift also harms peer supporters through moral injury and a wastage of capabilities, and ultimately impedes efforts to destigmatize mental health and addictions and include people with lived experience in the workforce. Understanding the magnitude of these harms can help us advocate for urgent efforts to address them.

9. Peer supporters experience the problem of peer support drift in different ways.

   Some peer supporters are at greater risk of harm from peer support drift and have fewer protections and supports to challenge it effectively. In our efforts to address peer support drift, we need to prioritize work to support those most affected.

Part 3:
Recommendations for Addressing Peer Support Drift and Protecting Peer Support Values and Standards (statement 10)

10. Addressing the systemic problem of peer support drift requires collective, properly resourced prevention and intervention led by people with lived experience.

    This final statement recommends the following actions to address and prevent peer support drift.

Recommendations for government and other sponsors of peer support

1. End discrimination against lived experience organizations and ensure equitable funding of consumer/survivor, peer-led, and peer support initiatives.
2. Develop stronger policy to support the equitable integration of peer supporters and values-aligned peer support into health and social welfare systems.
3. Support the independence and influence of peer-led initiatives and lived experience leadership in the health system.

Recommendations for the discipline of peer support

4. Continue to mobilize the discipline through consultation, collaboration, and collective decision-making to strengthen peer support and respond to peer support drift.
5. Review and enhance peer support standards to guide values-aligned practice.
6. Develop social justice-focused educational resources and professional development opportunities for those in varied roles across the peer support discipline.

Recommendations for peer support initiatives, leaders, and supervisors

7. Lead peer support programs in alignment with peer support values, standards, and best practices.
8. Continue advocating for the integrity and politicization of peer support and resisting peer support drift.

Recommendations for non-peer organizational and individual allies

9. Advocate for organizational decisions and actions that affirm the value of peer support.
10. Meaningfully collaborate with peer support colleagues by understanding and respecting their unique role and expertise.

Recommendations for peer supporters

11. Participate in peer support community, advocacy, and social justice work to politicize peer support practice and resist drift from values and standards.
12. Pay attention for and address situations and attitudes that can contribute to peer support drift.

Process for Developing the Position Statement

The statement, commissioned by the PeerWorks board of directors in September 2022 and approved in March 2024, has involved consultation with over 75 contributors. PeerWorks' membership and mailing list subscribers were invited to participate in a survey and/or focus group to share example tasks that peer supporters are being asked to perform that they feel are inappropriate. Regular meetings were held with an advisory committee composed of participants from PeerWorks' membership and the broader peer support community who represent different practice contexts and frontline, management, and research roles. The full statement went through three rounds of written and focus group feedback and revision.

PeerWorks' Position on Peer Support Drift

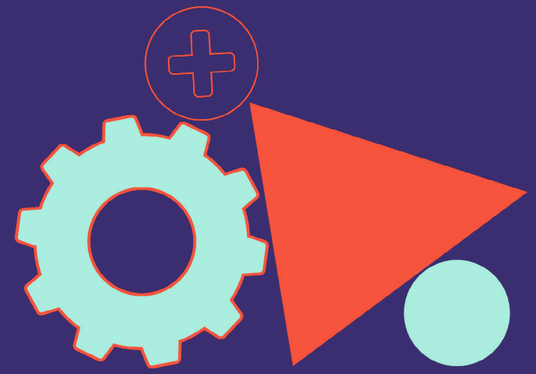
Our position is articulated here in ten statements, divided into three parts:

Part 1: The importance of protecting the history, values, and role of peer support (statements 1–3)

Part 2: Current challenges in protecting the integrity of peer support (statements 4–9)

Part 3: Recommendations for addressing peer support drift and protecting peer support values and standards (statement 10).

Part 1: The Importance of Protecting the History, Values, and Role of Peer Support



1 Peer support is — and must remain — rooted in social movement histories and values.

Peer Support Emerges from Social Movement Histories

Peer support is, in its most expansive sense, "a naturally occurring, mutually beneficial support process, where people who share a common experience meet as equals, sharing skills, strengths and hope; learning from each other how to cope, thrive and flourish" (PeerWorks, 2023b).

One tradition of peer support commonly enacted today in health systems in Ontario emerged from 1970s psychiatric consumer/survivor/ex-patient (C/S/X) movements forming nationally and internationally in English-speaking countries (Diamond, 2013). C/S/X movements were influenced by — and involved participants from and coalitions with — civil rights, Indigenous sovereignty, feminist, LGBTQ+, disability, and other liberation movements of the era (e.g., Corbman, 2020; Davidow, 2023; Jackson, 2002; Lewis, 2016; Piepzna-Samarasinha, 2016; Reaume, 2021; Thuma, 2014).[2]

As psychiatric institutions enacted a new policy of deinstitutionalization and discharge of patients into the community with inadequate support, ex-patients engaged in political action, such as exposing the dehumanization and violence of psychiatric practices, challenging involuntary treatment laws, seeking a right to refuse treatment, and advocating for livable income and housing and the elimination of stigma and discrimination (Boschma & Devane, 2019; Everett, 2000; Shimrat, 1997).

This grassroots activism also inspired the social movement organizing of people who use drugs and alcohol, survivors of the drug war, members of abstinence-based recovery support groups, and clients of addiction services (Smith, 2012, 2016). Indigenous communities continued healing work to address social suffering from colonization, discrimination, and colonial introduction of toxic substances (Maxwell, 2009). The HIV/AIDS pandemic encouraged greater coalition activism between people who inject drugs and other disproportionately impacted groups, including women sex workers, prisoner justice activists, and gay and racialized communities (Muncaster, 2023).

Drug user movements engaged in political organizing against punitive drug policies, criminalization, discrimination by police and medical services, and other structural forces perpetuating harm to drug users. They advocated for their safety, well-being, and legal rights and engaged in underground direct-action like distributing clean needles and facilitating unsanctioned safe consumption/injection sites.[3]

Consumer/survivor, drug user, and recovery groups also developed their own independent alternative supports, such as mutual aid and peer support, so that those who have been harmed by medical and psychiatric systems, or who are unable or unwilling to interact with mainstream services, have access to meaningful support. Peer support addresses the power imbalance between providers and recipients of services by focusing on "what people have in common and can teach each other, rather than on how one person may diagnose and treat another" (Crepaz-Keay & Cyhlarova, 2015, p. 247).

Peer support was initially available informally through naturally occurring interpersonal relationships and grassroots groups like the Ontario Mental Patients Association founded in 1977 (Weitz, 1984). People gathered in their homes, libraries, on the street, and other common spaces. Then increasing in the 1980s and 1990s, peer support was intentionally fostered through government-funded consumer/survivor and drug user-run organizations and non-profit community initiatives.[4]

We are now in what has been called the "third wave of development in peer support — the use of peer support within mainstream mental health services" (Cyr et al., 2010, p. 47).[5] This formalized model of structured peer support "begins when persons with lived [and/or living] experience who have received specialized training, assume unique, designated roles within the mental health system, to support an individual's expressed wishes" (PeerWorks, 2023b). The rest of this statement focuses on formalized peer support models delivered by paid and unpaid/volunteer peer supporters in mental health and/or addiction settings.

Peer Support Is Anchored in Social Movement Values

Peer support in the mental health and addiction context is anchored in the core values of consumer/survivor, drug user, and related social movements that have been affirmed through national (see Figure 2) and international consultation and consensus.[6] While national organizations across multiple English-speaking countries articulate their peer support values with slightly different terms, the values commonly speak to five themes:

1. **Identification with each other through shared lived experiences/expertise** (e.g., relational values of authenticity, mutuality, reciprocity, empathy, open-mindedness, acceptance, community, and experiential knowledge).

2. **Shared power in trusting relationships** (e.g., honesty, transparency, voluntariness, learning together, and respect, rather than exercising power over others).

3. **Strengths-focused understanding of mental health and addiction concerns** (e.g., hope, recovery, empowerment, wellness, lifelong learning, personal growth, and holistic person-driven support rather than a focus on illness, deficit, or pathology).

4. **Independent voice and choice in the mental health and addiction system** (e.g., self-determination, autonomous participation in decision-making, and peer-led initiatives that differ from dominant medical treatment models).

5. **Collective well-being through action and change to improve social conditions.** As peers spend time together and exchange knowledge in peer communities, we raise our awareness about the societal stigma and discrimination shaping our life possibilities, gain confidence and capacity to advocate for human rights and social justice, and seek liberation and inclusion.

An international consortium of peer support leaders from six continents reached consensus on a core set of guiding principles for peer support that emphasize how peer support ought to be "based on a human/civil rights perspective," practiced "with integrity to its founding values in a...social justice framework," and involve "advoca[cy] for changes, both in systems of care and in the broader society, to eliminate discrimination" (Stratford et al., 2019, pp. 630-631). The consortium leaves open which human rights and social justice approaches are most suitable, encouraging peer support practices culturally responsive to local worldviews.

Accordingly, we advocate that the politicized foundations of peer support in social movement histories and values remain strong throughout peer support practice. We support the practice standards advanced by Peer Support Canada that all peer supporters ought to "be familiar with the historical context in which peer support has arisen" and to understand the effects of and ways to mitigate prejudice and discrimination (Peer Support Certification and Accreditation Canada, 2016, p. 10; also see Sunderland & Mishkin, 2013). Locating peer support values in our social movement history helps inspire peer supporters to live out these values with loyalty and integrity.

2 The peer support role is unique, and this uniqueness is valuable and must be protected.

In Canada, foundational guidelines and standards for formalized peer support in the mental health and addiction system describe the uniqueness of the peer support role, including: (I) the nature, philosophy, and purpose of peer support; (II) core values and principles of peer support; (III) the skills, abilities, knowledge, and experiences required of peer supporters; and (IV) minimum standards for ethical practice (see Support House: Centre for Innovation in Peer Support, 2022; Peer Support Certification and Accreditation Canada, 2016; Sunderland & Mishkin, 2013).

Standards were first introduced in 2013 to provide peer supporters across Canada with a shared vision for how to practice. The hope was that standards and Peer Support Canada's certification pathway would "enhance the credibility of peer support as an essential component of a transformed mental health system and encourage its use" (Sunderland & Mishkin, 2013, p. 8), "endorse peer support work as a valid and respected career," and ensure that peer supporters are "competent and trained for peer support work" (Peer Support Accreditation and Certification Canada, 2016, p. 5). These documents continue to play a vital role in guiding peer support practice in Canada.

To better understand and respect the unique essential elements of peer support, it is important to distinguish the peer support role from the work of other health professions. As illustrated in Figure 3, a significant difference is that peer support endeavours to reduce hierarchy and share power between peers, whereas regulated health professions are given and use significant power.[7]

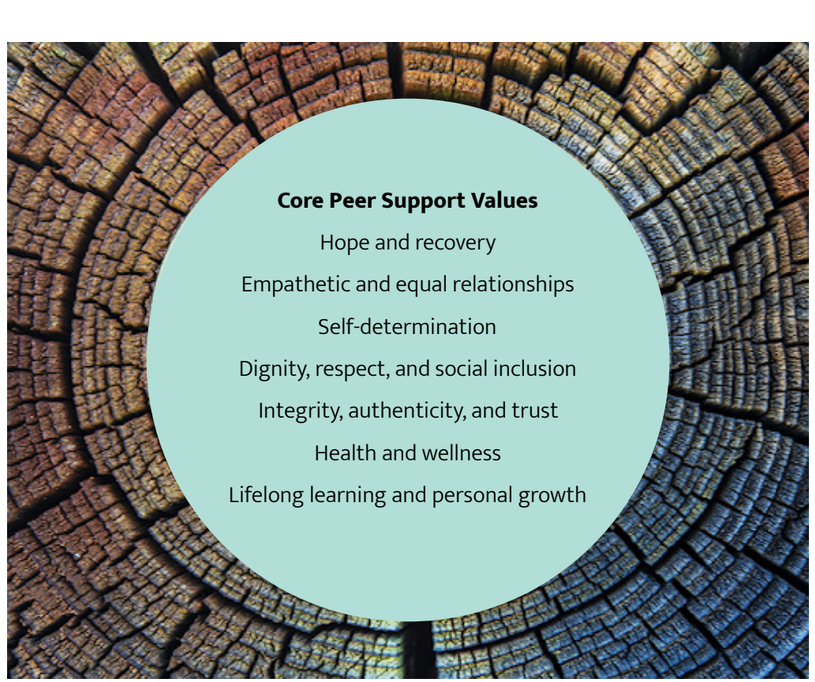
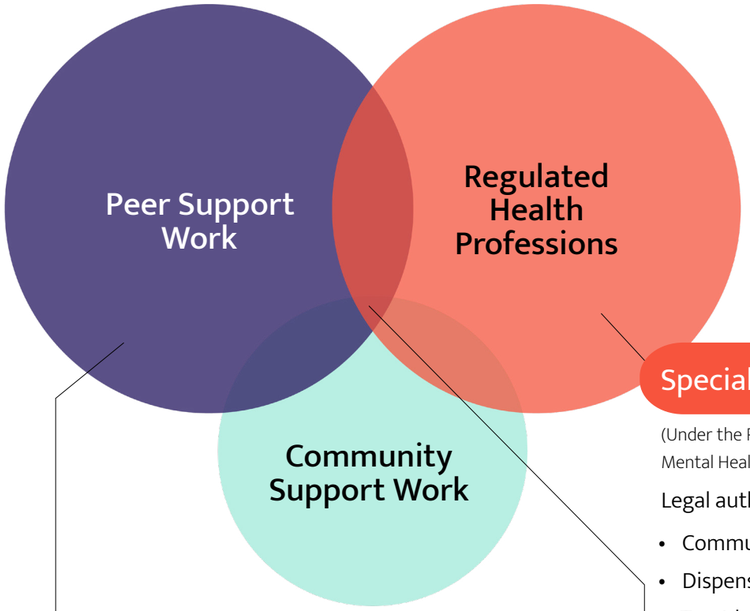


Figure 2. Core Values of Peer Support in Canada (from Peer Support Canada, 2019)



Special to Peer Support

Core Values

Hope and recovery; empathetic and equal relationships; self-determination; dignity, respect, and social inclusion; integrity, authenticity, and trust; health and wellness; lifelong learning and personal growth

Core Activities

- Forming voluntary, mutual, and reciprocal relationships with peers that strive for a sharing of power and minimization of hierarchy
- Intentionally sharing lived experience in a manner that demonstrates understanding and inspires hope for recovery
- Using knowledge gained from personal experience to contribute to the wellbeing of peers
- Respecting the self-determination of peers and their right to make their own choices
- Focusing on recovery, empowerment, and strengths rather than illness and deficit
- Facilitating social justice and inclusion rather than maintenance of the unjust status quo

Special to Other Health Professions

(Under the Regulated Health Professions Act, Health Care Consent Act, Mental Health Act, Patient Restraints Minimization Act, other legislation)

Legal authorization to:

- Communicate a diagnosis
- Dispense a drug
- Treat by means of psychotherapeutic technique
- Complete applications and certificates that detain people in psychiatric facilities involuntarily
- Write orders to restrain or confine people
- Find a patient incapable of making treatment decisions
- Use protected professional titles
- Report a vehicle driver for medical review
- In an emergency, treat a patient without consent

Shared Across Caring Roles and Applicable to Peer Support

- Treating people with respect and dignity
- Caring for others with empathy and compassion
- Behaving with honesty and integrity
- Maintaining confidentiality
- Collaborating with community partners
- Connecting people to other resources
- Practicing in a way that upholds ethical behaviour and does not knowingly cause harm (e.g., no romantic relationships with people supported, not taking advantage of the relationship)
- Engaging in lifelong learning and maintaining currency in one's field
- Practicing in a way that maintains public trust and confidence in the discipline

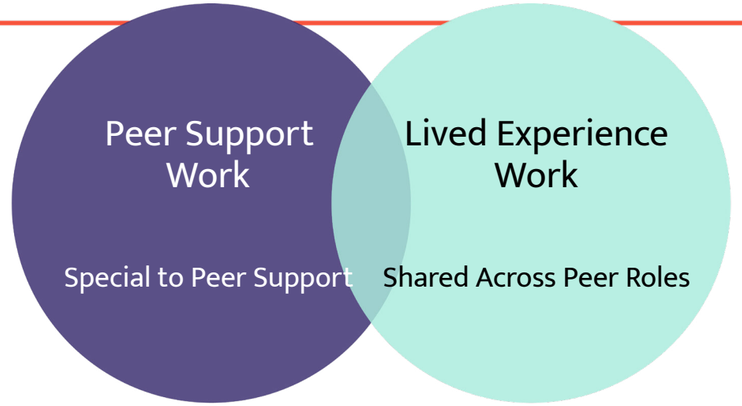
Figure 3. Role Differences Between Peer Support, Health Professions, and Community Support Work

3 Preserving the term "peer support" and the variety of approaches to peer support help to protect its unique role and contribution.

Peer Support Roles Have Unique Differences from Peer Roles

Formalized peer support entails drawing on lived experience and specialized peer support training "to support an individual's expressed wishes" (PeerWorks, 2023b). Some peer supporters have the term "peer support" reflected in their job title (e.g., peer support specialist, peer support worker). Others do not but are nonetheless recruited to provide peer support in alignment with peer support values and guidelines (see Cronise et al., 2016).

There are numerous other ways in which people with direct and personal lived or living experience[8] of a mental health or addiction concern contribute to the healthcare system that do not take the form of a peer support role (see Figure 4). For example, they may hold leadership, advocacy, education, policy development, or research roles — rather than direct support roles — and serve as a board member, manager of a peer support program, peer educator, or participant in a codesign or patient engagement project. People with lived experience may also work in supported employment programs, which commonly involve forms of service work like cleaning, food preparation, and package delivery (Edan et al., 2021; Government of Western Australia Mental Health Commission, 2022a; Hopkins & Gremmen, 2002b, p. 17-18).



- Forming voluntary, mutual, and reciprocal relationships with peers that strive for a sharing of power and minimization of hierarchy
- Using knowledge gained from personal experience to contribute to the wellbeing of peers
- Respecting the self-determination of peers and their right to make their own choices
- Intentionally sharing one's lived experience in a manner that demonstrates understanding and inspires hope for recovery
- Focusing on recovery, empowerment, and strengths rather than illness and deficit
- Facilitating social justice and inclusion rather than maintenance of the unjust status quo

Figure 4. Activities Special to Peer Support and Shared with Lived Experience Work

In such roles, lived experience may be a required attribute and peers may draw on their experiential knowledge, but the role is not centred on the defining feature of peer support, which is to use this lived experience to support another individual's recovery journey. Therefore, these other roles should not be called "peer support" but instead carry a different title more appropriate to the nature of the work performed (e.g., peer researcher, social worker with lived experience).[9] While lived experience is required for a peer support role, the role itself is defined by the enactment of core peer support values and activities rather than the identity of the person practicing those activities. Having lived experience does not make one a peer supporter.

Maintaining these distinctions between peer support work and lived experience work is important for maximizing peer support availability and ensuring funding dollars for peer support deliver it rather than another type of practice mislabeled as peer support. Moreover, it is much easier for peer support to drift away from its core values and standards, and much harder to establish public trust in peer support, when the term "peer support" is confusingly used to refer to non-peer support practices.

Peer-Led Initiatives Offer Unique Approaches to Peer Support

Peer support is practiced across diverse settings. One setting, independent consumer/survivor initiatives (CSIs) (also referred to as peer-led initiatives), are crucial custodians of the history, values, goals, and culture of the consumer/survivor movement.

CSIs cultivate and protect peer support values through their unique structure and approaches: They strive to be low barrier with an open-door policy where peers can access support on a drop-in, anonymous basis with no waiting list, intake process, exclusion criteria, or health record tracking. CSIs also aim to be flexible, non-medical, and membership-based spaces that meaningfully welcome and include those most affected by marginalization who have been harmed by or otherwise distrust mainstream services. CSIs provide a broad range of peer support options, including fostering spaces where friendships and community can develop naturally among participants, artistic and cultural activities, knowledge development and skills training, public education, individual and collective advocacy, and more structured one-on-one and group support.

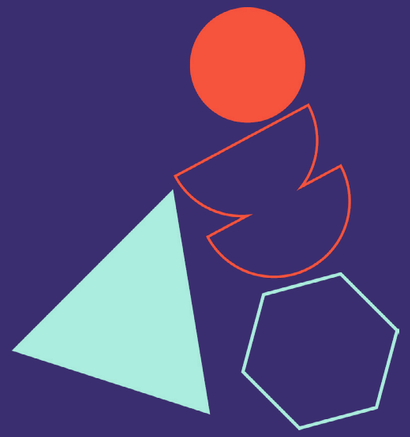
> **"It's nice to have a safe space where you can talk [...] as freely as you want to. And everybody has some kind of addiction experience and it's just like walking into a warm hug. Everybody's there to support you and understands what you've been through."**
>
> (Peer cited in Pauly et al., 2021, p. 5)

Most importantly, all aspects of CSI governance and horizontal decision-making at the level of the board, director, staff, and membership are democratically led and controlled "by and for" people with lived experience (Campbell, 2005; Chamberlin, 1978; CMHA et al., 2005; Trainor et al., 1997). The comparatively small size of these independent local initiatives is strongly valued as this type of community ownership and accountability, flat distribution of power, and internal leadership development of staff is often much harder to facilitate in large, hierarchical, and bureaucratic mainstream mental health settings (Reville, 2006; Schaaf et al., 2020).

Peer support is also increasingly provided within mainstream mental health services. Peer support in these settings should still reflect the core values and activities of peer support, but it is often approached differently than at a CSI as a result of how it is positioned within the organizational structure. For example, peer support programs may report up to a leader without lived experience, require a formal intake to access services, and offer fewer formats of support due to the dominant individual-focused care model in place (see TaylorNewberry Consulting, 2014). These differences are not an unmanageable problem in and of themselves but can combine into unideal conditions that make it more challenging for peer supporters in these settings to practice values-aligned peer support, as will be discussed in the next section.

In short, there is often a significant difference between "social movement organizations" like consumer/survivor initiatives that focus on structural change and "service provision organizations" like peer support programs in mainstream services that focus on excellent service delivery (Michaud et al., 2016). Recognizing these distinctions is important for ensuring independent peer-led initiatives are equitably funded and supported relative to peer support programs in mainstream settings, and that the full variety and range of peer support options is preserved across the province (Faulkner & Kalathil, 2012). This is particularly crucial because, although we led the world when the Government of Ontario funded more than 60 independent peer-led initiatives in the 1990s, we are down to only 10 today through closure, absorption, and amalgamation with large health organizations (Nelson et al., 2008; O'Hagan et al., 2009).

Part 2: Current Challenges in Protecting the Integrity of Peer Support



4 Institutionalization into mainstream health systems is contributing to the depoliticization of peer support.

A common pattern across social movements is that many evolve over time from grassroots to mainstream as they grow, get funded, and move into institutions governed by relevant law and policy. The trajectory of peer support from informal relationships towards government-funded organizations and the contemporary emergence of the paid "peer support worker" is one example of this trend (see Adams, 2020; McLean, 2000; Michaud et al., 2016; Smith, 2012; Smith-Merry & Sturdy, 2013).

> **"[T]he meaning and practice of recovery and peer support are significantly recalibrated when they move from 'movements' into 'models,' and such models (informed by clinical logics and outcomes) are absorbed into dominant mental health practices."**
>
> (Voronka, 2017, p. 334)

> **"Addiction treatment institutions tend to emerge through the efforts of grass roots movements and then become divorced from such movements and the wider community as they mature. Services that emerge out of a 'we' position often evolve toward services provided by 'us' to 'them.'"**
>
> (White, 2001, p. 9)

Incorporation into the mainstream is not inherently bad. It can reflect the realization of movement goals and bring with it numerous benefits—including opportunities to support more peers through increased resources; to inform decisions and changes to dominant knowledge, policy, and practice; and to diversify participation (Janzen et al., 2006). However, movements often become "depoliticized" or "deradicalized" during the process of institutionalization, as illustrated in Figure 5. This means movements become less focused on addressing the root causes of the oppression people face (Epstein et al., 2023).

For instance, over time, the critical recovery and harm reduction philosophies of the consumer/survivor and drug user movements have been appropriated into dominant healthcare models, practices, and policy. They have become part of — and less a critique and alternative to — the medical system (see De Ruysscher et al., 2019; Rose, 2014; Smith, 2012).

"And then he [a clinical director] spoke about recovery, and his view of it. He had this slide that said why recovery was important. These were the things that were on it:

- **Recovery is a paradigm that can be adapted across care spectrums.**
- **Recovery has the potential to create service efficiencies.**
- **Recovery focusses on individual outcomes.**

Last time I checked, recovery was a social change movement that has the potential to change cultures and focusses on social outcomes. But this is how it is taken into services."

(Watson, 2020, p. 146)

"Some see the expansion of paid 'peer' staff positions as a sign of progress: an indication that psychiatry is becoming more open to including the perspectives of service users in the design and delivery of services. Others see this development as a co-optation of survivors' experiential knowledge to benefit public mental health systems, leaving intact the coercive structure of systems that rely on the deprivation of liberty and forced treatment."

(Penney & Prescott, 2016, p. 38)

"On the one hand, peer support was enthusiastically promoted by peers and professionals alike as an avenue towards autonomy and inclusion, inspired by aspirations for social freedom, justice, community, and mutuality. On the other hand, the neoliberal turn also consolidated demands for the standardization and formalization of peer support as a form of employment, thus enhancing processes of individualization and emphasizing productivity and professionalization."

(Boschma & Devane, 2019, p. 68)

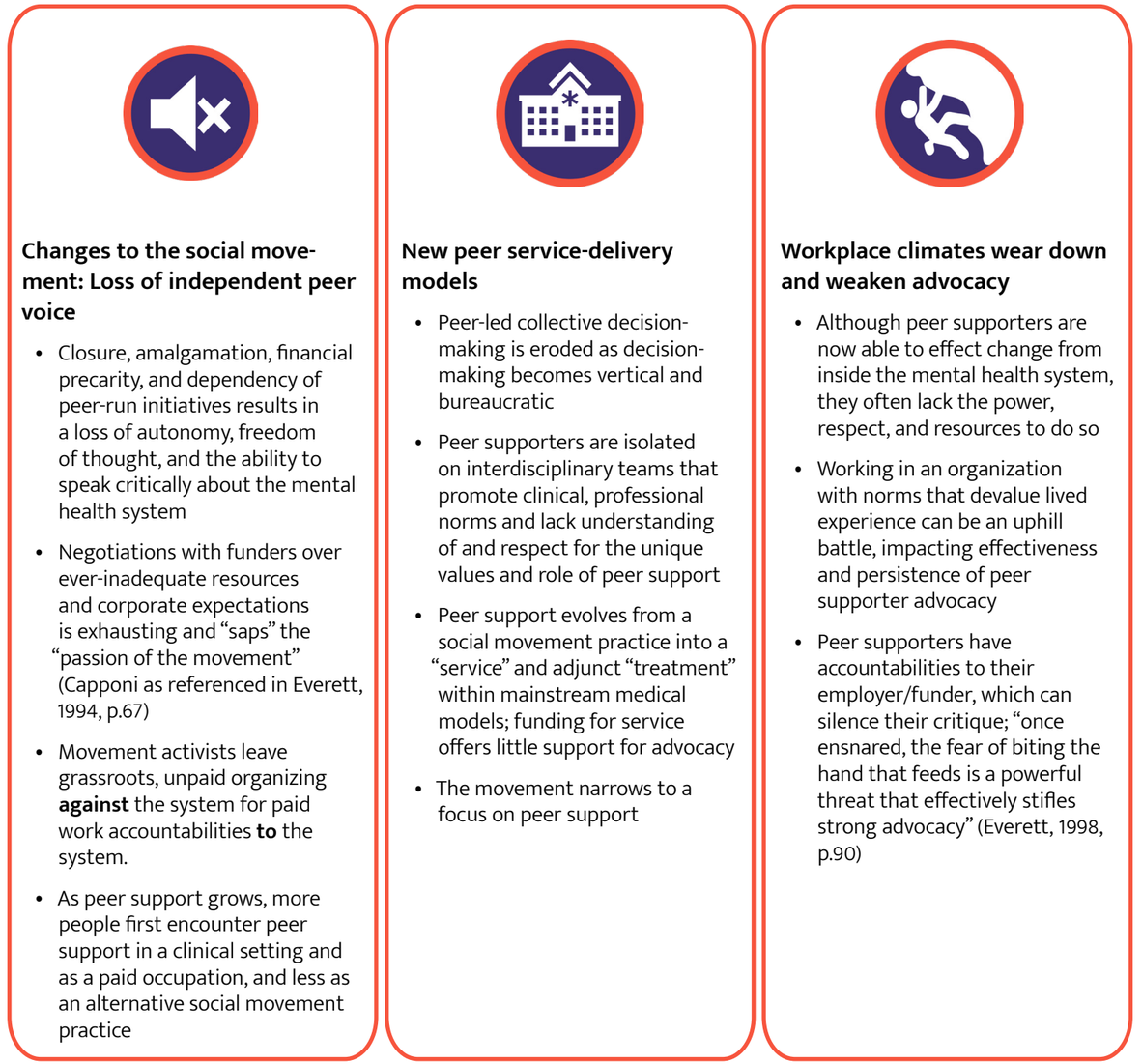


Figure 5. Effects of Institutionalization on the Depoliticization of Peer Support

The drawbacks of institutionalization and depoliticization are raising increasing concern that the practice of peer support in the mainstream mental health and addiction sector is drifting from the values and intentions of its social movement history. In short, "the links between the consumers' movement and peer support are becoming somewhat attenuated" or weakened (Scott, 2015, pp. 39-40; White, 2001). Page and Woodland (2023) describe this phenomenon of co-optation as "the strategic displacement of a people from the source of their wisdom and power... where we no longer know how to be in right relationship to lineage, traditions, and collective wisdom generated across time and space" (p. 252).

5 Peer support practice is drifting from its core values and special role.

Peer drift, role drift, and co-optation are the terms most commonly used to refer to a shift in peer support practices away from peer support values and standards.[10] In this statement, we use the term peer support drift to emphasize the systemic nature of drift within the discipline of peer support rather than as a lapse of individuals.[11]

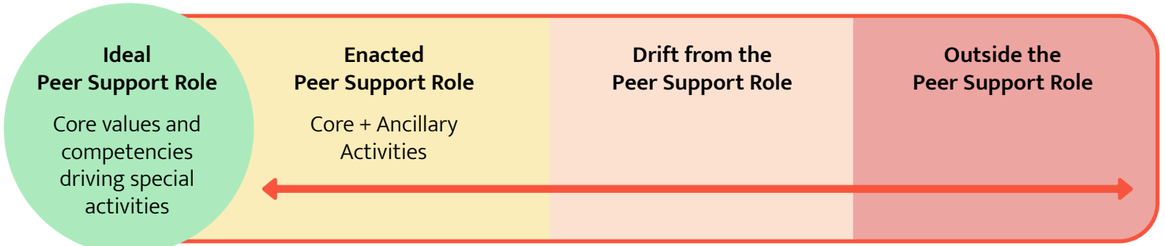


Figure 6. Spectrum of Peer Support Practice from the Ideal Peer Support Role to Outside the Peer Support Role

Concern about the challenges of peer support programs "remain[ing] true to their roots," drifting from peer support values, "default[ing] to being like traditional services," and "slip[ping] into a type of interaction that no longer honours the original intent…[or] critical elements" of peer support has been raised by peer supporters and government for over 30 years.[12] Long before this, activists in the consumer/survivor movement worried about co-optation and "developments that contradicted the movement's initial goals," such as changes brought about by the acceptance of government funding (McLean, 2000, p. 835; Chamberlin, 1978; Emerick, 1991; Fisher, 1994). When drift occurs at scale, the peer support movement can be "so fundamentally transformed that the (potential) challenge it poses to dominant power relations is reduced" (Morgen, 1986, p. 203).

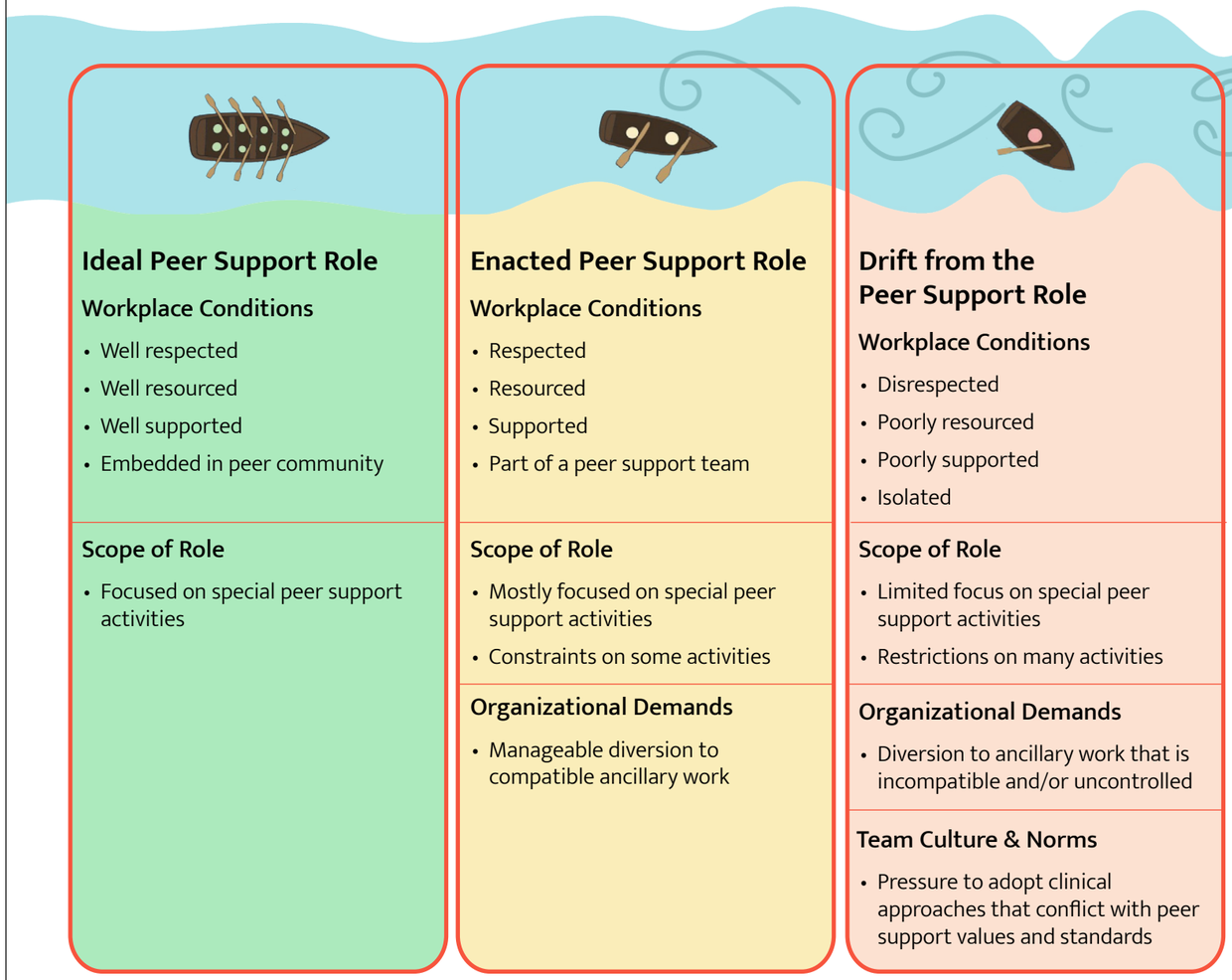


Figure 7. Ideal, Enacted, and Drifted Peer Support Roles[13]

Drift is best understood on a spectrum from ideal peer support at one end to activities beyond the peer support role at the other end. Figures 6 and 7 depict and further describe this spectrum. The ideal peer support role is depicted in green ("Go!"). We are in the ideal zone when peer supporters are practicing with integrity and in alignment with peer support values and standards and spend most or all of their time on the activities special to peer support that add the most value.

Given the demands and constraints of the real world, it can be understandably challenging to fully realize this ideal role, and so we may find ourselves in the next zone. The enacted peer support role, depicted in yellow ("Caution!"), reflects an ethically justifiable approach to the practice of peer support in the actual conditions of the workplace. This includes most or all of the aspects of the ideal role, as well as participation in some appropriate ancillary or peripheral activities to support the operations of a peer support program. Ancillary activities may not maximize a peer supporter's unique contribution but are nonetheless reasonably required to run a peer support program within a particular context.

For example, peer supporters may need to respond to administrative emails, document attendance statistics for funders, or put in orders to refill supplies. These activities may not optimize a peer supporter's special skills of building mutual relationships and drawing on lived experience to support a peer but can be justified as appropriate work for a peer supporter when they are legitimate, fair, equitable, proportionate, and safe. Peer supporters, in consultation with peer support colleagues and disciplinary guidelines, are best positioned to determine whether work meets these criteria (see Figure 8).

Drift from the peer support role is coloured orange ("Danger!") because it reflects low quality peer support and departure from peer support values and standards. In red ("Stop! Do not enter!") at the end of the spectrum are activities outside of the peer support role.

Legitimate

- Compatible with peer support standards and values (e.g., supports self-determination, dignity, and respect of the peer supporter)
- Appropriate for the peer support role (i.e., not more appropriate for another role)
- Determination of an activity's legitimacy is made by a legitimate authority (i.e., peer supporters and the peer support discipline)

Equitable

- Distributed across employees, without disrespect or discrimination towards a particular employee class
- Assigned through an equitable process (e.g., peer supporters participate in decision-making about task allocation and have opportunity to express and have preferences considered, with a focus on work that they are good at and areas where they want to grow)

Fair

- Aligns with organizational policies
- Properly recognized and compensated (e.g., consistent with a person's job description, skill level, and rate of pay; completed within work hours)

Proportionate

- Comprises a small proportion of a peer supporter's overall work time compared to the core and special work of peer support

Safe

- Any safety concerns of the ancillary work (e.g., physical or psychological safety, safety from moral distress) are mitigated and minimal

Figure 8. Criteria for Determining the Appropriateness of Ancillary Work for Peer Supporters

6 Peer support drift occurs at the level of individuals, organizations, and systems, and tends to take two forms: drift into clinical and menial work.

PeerWorks takes the position that peer support drift is systemic and must be addressed at the level of organizations and health systems. Working conditions can push peer supporters to drift, so we also need strategies to support them in protecting the peer support role. Below we discuss two manifestations of peer support drift: drift into clinical and menial work. While we start with familiar examples at the level of peer supporters, we trace these micro manifestations of drift back to more systemic issues.

Drift into Clinical Work

Drift into medical or clinical approaches reflects a prioritization of the interests and values of the psychiatric system over those of peer support. It can also contradict the core principle that "[p]eer support does not serve a social control function" (Stratford et al., p. 4) or try to influence or regulate the actions, beliefs, or movements of a peer.

At the individual level, this can show up as a peer supporter encouraging peers to follow clinical advice rather than make their own self-determined choices, or as a peer supporter using deficit-focused medical language rather than the strengths-focused recovery philosophy of peer support. Peer supporters may stop engaging in mutual relationships with peers, and instead adopt more distant and hierarchical clinical boundaries and approaches.

When this kind of drift occurs, "[p]eer support is gradually transformed from a relationship between two people with shared experience to an intervention provided by one person to support the other" (Watson, 2019, p. 31). Figure 9 depicts this drift of a peer supporter into a clinical mental health role.

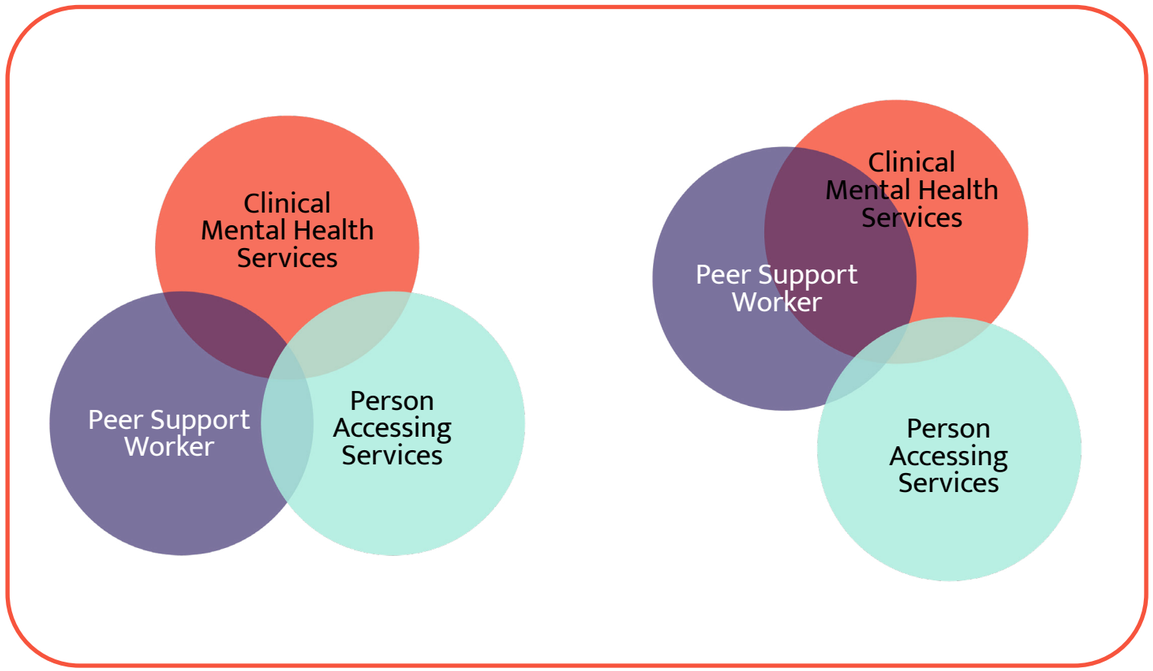


Figure 9. Illustration of Peer Support Drift into Clinical Approaches (from Phillips, 2018)

> **"They changed the scope of what peer support really is. At the end of the day, again, I believe peer support is one peer sharing his or her story with another. Now there's that movement that kind of makes people, what I like to refer to as mini clinicians. Minus the white coat, they've got their clipboard and they're taking notes, 'How does that make you feel?'"**
>
> (Former peer supporter cited in Adams, 2020, p. 4)

> **"By over-identifying with [clinicians and clinical training]... the recovered person may refute the value and legitimacy of their own experience in ways that diminish their empathy and connectedness to [peers] who seek their services... Emotional detachment in the name of professionalism may neutralize the most important assets the recovered person brings to the field of addiction treatment. When this happens on a large scale, ...all clinically important differences between [service providers] with and without recovery backgrounds will have dissipated."**
>
> (White, 2000b, p. 11)

At the level of peer support programs in organizations that are not peer-run, drift into clinical roles may be enshrined in policy, resulting in "mainstream services... adapting peer support to their own values rather than the values of the consumer/survivor movement" (Cyr et al., 2010, p. 47). For example, organizations may devalue lived experience, perhaps perceiving it as irrelevant or unprofessional, and privilege learned expertise. This perspective often underlies job postings that require peer supporters to hold a postsecondary credential and registration with a health profession (Epstein et al., 2023; Mamdani et al., 2021).

Organizations may also enforce confidentiality and boundary policies that restrict what peer supporters can disclose and discuss with the peers they support. These organizational decisions contribute to peer support drift through the recruitment of people more immersed in clinical and medical treatment paradigms rather than lived experience, and by restricting core peer support activities (Adams, 2020; Hopkins & Gremmen, 2022b; Mead & Filson, 2016; Stratford et al., 2019).

> **"Self-help gets lost in bureaucracy."**
>
> (O'Hagan, 1993, p. 78)

> **"I started out trying to be me: the person that I am, trying to get anybody I can healthy and direct them to resources. But they shut me down, saying it had to go through their operation and procedure, and I don't know what their procedure is."**
>
> (Peer participant cited in CMHA, BC Division, 2023a, p. 34)

Clinical colleagues may encourage peer support drift when they expect peer supporters to "help" them exert authority over and direct client behaviour. For example, through performing tasks like urine drug screens, room/belonging searches, medication monitoring, risk assessments, or training on the use of restraints, where peer supporters "lose the distinctness of their role," notably their nonclinical, noncoercive, voluntary, and consent-based approach (Faulkner & Kalathil, 2012, p. 34). Instead, peer supporters take on "more-of-the-same generic roles" which "discount their unique contribution to mental health services and the hopes of system transformation" (Rebeiro Gruhl et al., 2023, p. 92).

These examples of individual and organizational drift can be in part explained by drift at the level of health systems where values of cost-effectiveness or risk management are prioritized over peer support values. Funders may impose expectations on peer support programs that dramatically reshape their practice (Bennett & Savani, 2011; Penney & Prescott, 2016).

"And you would hope [the peer support role] would not become...a cheaper version of a [nurse]. ...I think there is a potential...we just become somebody else who can take medication out."

(Nadia, cited in Dyble, 2012, p. 135)

"[T]he people who wrote the job description and were creating the team were not entirely sure what they wanted in a peer [supporter] and how this person was going to be different from everybody else. ...I didn't come here to work as an underpaid social worker."

(Rachel, cited in Voronka, 2015, p. 315)

"I constantly have to stop workers from handing out personal details to me when they have not gained permission from the individual to do so. ...[E]arlier on in peer roles, I found myself hearing an individual's personal history from their case manager before I had even met the individual."

(Sinclair, 2018, p. 168)

"The [government funder] want[s] peer support in a specific way. We have to abide by that... The traditional way of doing peer support, just sitting down and having a cup of coffee, is not there anymore."

(Supervisor of a peer-led initiative cited in Adams, 2020, p. 4)

"[T]he funding applications that you're writing, you're not writing what you really need, you're writing what is [attractive] to the funder."

(Organization cited in Mood Disorders Association of Canada, 2022, p. 12)

"Once funded, people often stated that funders tried to reshape peer support services and gave them the same reporting requirements as mainstream services. This was seen as a sign that funders did not understand what they were 'buying.'"

(Cyr et al., 2010, p. 71)

Paradigms used to produce the evidence base for peer support have also contributed to drift. For example, researchers investigating the efficacy of peer support have muddied the evidence by conflating several different approaches together (e.g., peer support, case management, mentorship/coaching, behavioural support). This conflation likely underestimates the unique contribution of peer support and encourages implementation of a confused version of it. Additionally, research often focuses on evaluating one-on-one structured peer support and on quantitative clinical, economic, and service outcomes, and infrequently includes peer supporters as part of the research team. This leads to limited research on independent peer-run initiatives, peer support focused on community building or advocacy, or social change outcomes that lie at the heart of peer support (Gillard, 2019; Standing Senate Committee on Social Affairs, Science and Technology, 2006; Watson, 2019; White et al., 2020).

"So here is where we might pause and take stock... [A]s researchers we seem to be starting to suggest that good peer support in mental health services might be about illness management... reflecting an essentially medical model of mental health; that there is something wrong with you that a peer worker can support you to fix. ...Funders of mental health services, quite correctly, will turn to this strengthened evidence for guidance on what models of peer support they should be commissioning going forward. ...[I]s this the full scope of what we want peer workers to be doing, the best we can ask and expect of peer support?"

(Gillard, 2019, p. 341)

"[People with lived experience] have legitimate grounds for being suspicious of many traditional research methods... With the increased incidence of government funding, however, some groups are grappling with defining best practices, hoping that by adopting the methods of the professional culture they will gain respect and compete more effectively for funding."

(Standing Senate Committee on Social Affairs, Science and Technology, 2006, p. 244)

> **"Whose knowledge matters? Should research into peer support be carried out by professionals using the standards that are used to judge other interventions, or should peer support be looked at using the standards which it defines for itself? For many survivors, the object of peer support is social change, and this is what should be measured in order to understand the success of peer support."**
>
> (Watson, 2019, p. 33)

By promoting misunderstandings of peer support and influencing which forms are studied, proven "effective," and approved for funding, researchers and research paradigms are complicit in peer support drift.

Drift into Menial Work

As previously noted in the description of the "enacted peer support role," it is reasonable in the real-world conditions of a workplace to expect peer supporters to participate in some of the ancillary work needed to run a peer support program. However, inappropriate forms, quantities, and assignment of these duties can push peer supporters away from the core values and activities of their discipline.

For example, peer supporters have described being tasked with low responsibility, menial and/or administrative tasks like "grunt work" and "dirty work," cleaning, driving clients, answering the phone, ordering office supplies, updating the website, or making flyers (Epstein et al., 2023, p. 23; Dyble, 2012; PeerWorks, 2022a).[14] Colleagues and organizational structures are often involved in the delegation of these tasks to peer supporters (SAMHSA 2022).

> **"Sometimes when I get [to work] and I'm barely even in the door [support workers are] like, 'you gotta go upstairs and go clean the kitchen. You gotta go in here and clean the staff room.'"**
>
> (Peer supporter cited in Mamdani et al., 2021, p. 6)

Peer support guidelines therefore make explicit that peer support is not "running errands", "making coffee", or "a transport service" (Government of Western Australia Mental Health Commission, 2022a).

Assigning service work to peer supporters conflates their role with supported employment for people with lived experience. As addressed in statement 3 above, such misunderstandings reduce the availability, provision, and impact of direct peer support. Peer support drift into menial work also reflects discrimination and disrespect, where "peers are expected to do tasks other [staff] think of as 'beneath them'" (Epstein et al., 2023, p. 23; Mancini & Lawson, 2009).

> **"As a hospital peer support, other staff often declare that a task is the peer supporters' as no one else wants to do it. This includes selling raffle tickets, ordering supplies, etc."**
>
> (Survey participant, PeerWorks, 2022a)
>
> **"I am a harm reduction worker. We were actually literally hired to give knowledge about substance use. Not serve food, not clean toilets. It seems these jobs that nobody else is willing to do fall on peers."**
>
> (Participant cited in Epstein et al., 2023, p. 23)

7 Peer support drift is a political, legal, and ethical problem.

Drift from peer support values and standards is widely acknowledged by peer supporters as a problem. However, the nature of the problem — what kind of problem it is — has been less well defined. By understanding peer support drift as a political, legal, and ethical problem, we can further clarify the range of harms involved and what is required to address them.

Peer Support Drift is a Political Problem

Peer support drift is a political problem because it relates to the actions (and inactions) of the government and reflects, at least in part, a lack of government follow-through with publicly stated commitments.

Since at least 1988, Canadian federal and provincial governments have acknowledged the essential role that peer support plays in mental health and addiction services.[15] They have recommended that organizations "actively seek to involve peer support workers in all aspects of service delivery" (Select Committee on Mental Health and Addictions, 2010, recommendation 14) and that funders "increase appropriately resourced peer support initiatives in both independent, peer-run agencies and mainstream settings" because "[d]espite its effectiveness, peer support gets very limited funding" (Mental Health Commission of Canada, 2012, p. 71).

"Each community...should have consumer and self-help groups as part of the range of service options. These groups should be consumer-controlled... [S]elf-help and peer support should be considered a necessary ingredient of successful health system. ... Advocacy should be an integral part of mental health services."

(Graham & Provincial Community Mental Health Committee, 1988, pp. 53-54)

"Ontario has developed a vision of a mental health system where...funding will be reallocated to help consumer/survivors and families develop alternatives to the formal mental health system."

(Ontario Ministry of Health, 1993, p. 13)

"[F]unded [Consumer/Survivor] organizations were not to provide such services as counselling or case management...but to build upon the culture of mutuality and experiential knowledge that is the centre of self-help...

The rise of the self-help movement in mental health and addiction heralds a significant change in the traditional power relations in our systems of care. With...ongoing government commitment and protection, its full benefits will be realized...

[Peer support] organizations must be supported through stable, adequate, annualized funding. They must also be included in public education, research and knowledge transfer activities and thereby support the growth and development of structures and skills that enable all organizations...to operate effectively."

(Standing Senate Committee on Social Affairs, Science and Technology, 2006, pp. 236, 246)

"Indeed, advocacy by organizations run by people with lived experience has brought about many positive changes in public policy... At the same time, various factors—most notably the lack of adequate funding—continue to limit the ability of people living with mental health problems and illnesses to advocate. Better support must be provided for advocacy organizations..."

(Mental Health Commission of Canada, 2012, p. 44)

Despite these acknowledgments, peer support, particularly that offered by independent, peer-run organizations, continues to be underfunded, which contributes to a lack of power and resources to prevent and address peer support drift. While the provincial government has specially funded wage increases and professional development for other health professions, and reduced barriers to workplace health insurance (e.g., Government of Ontario, 2016, 2017, 2022), similar considerations have not been offered to peer supporters. In the last several years, Ontario Health has also enhanced its commitments to addressing equity, inclusion, diversity, and anti-racism (Corpus Sanchez International, 2020; Ontario Health, 2020). It is not yet clear how these commitments will extend to supporting equity for peer supporters and peer-led programs.

Another way in which peer support drift is a political problem arises from the lack of government understanding and respect of the unique scope and role of peer support. It is not uncommon for the scopes of practice of health professions to change in response to evolving social conditions like workforce shortages, scientific developments, patient needs, and aspirations for professional growth. However, it is very important that any changes in scope are decided by the collective of practitioners, justified by a defensible evidence base, informed by stakeholder consultation, responsive to service user needs, accompanied by appropriate training and education, and carefully implemented with disciplinary oversight (Royal College of Physicians and Surgeons of Canada, 2019).

Due to the limited application of these considerations to peer support, peer support practice is drifting rather than changing through deliberate decision-making with diligent oversight. Policymakers, funders, employers, and managers of peer supporters have been changing the role and scope of peer support as it is institutionalized into mainstream health settings and contorted to fit existing structures misaligned with peer support values (see Adams, 2020; Cyr et al., 2010). These changes to the scope of peer support can result from misunderstanding what peer support is (and is not), carelessness in integrating peer support without due concern for protecting its unique core features, neglect manifesting as insufficient resources and support, or a lack of preparedness for the organizational transformations advocated by peer supporters (Sinclair et al., 2023).

Peer Support Drift is a Legal Problem

Peer support drift is a potential legal problem as peer supporters commonly attribute drift to unsupportive and stigmatizing work environments that devalue peer support and lived experience (e.g., Adams, 2020; Mamdani et al., 2021; Rebeiro Gruhl et al., 2023). Expectations that cause peer supporters to drift from the scope of their role into clinical or menial work may reach a threshold of constituting a violation of relevant human rights and labour law on the protected grounds of (mental health and/or substance use) disability. Even if pressures to divert from their proper role do not meet the legal standard of discrimination, these demands definitely do not reflect best practices and guidance provided by the Ontario Human Rights Commission with respect to creating a non-discriminatory workplace that complies with Ontario's Human Rights Code (Ontario Human Rights Commission, 2008, 2012, 2016).

For example, peer supporters are protected by Article 27 of the United Nations (2008) Convention on the Rights of Persons with Disabilities, which outlines how people with disabilities have a right to "just and favourable conditions of work, including equal opportunities and equal remuneration for work of equal value, safe and healthy working conditions, including protection from harassment, and the redress of grievances" (section b). Nation states like Canada that have ratified the Convention are also expected to promote disabled people's access to employment opportunities and career advancement (section e).

Within federal and provincial law, organizations have a duty to maintain non-discriminatory workplaces, to take steps to address and eliminate an environment poisoned by disrespect, and to protect worker health and safety through identification and mitigation of workplace hazards and prevention of workplace violence (see Canada Occupational Health and Safety Regulations and Ontario's Human Rights Code and Occupational Health and Safety Act; Government of Canada, 2016).[16] Organizations must also follow employment standards for compensation and workplace conditions (see Employment Standards Act; CMHA, BC Division, 2023a, pp. 45-46).

Accordingly, an organizational culture where peer supporters face disrespectful conduct that should be known to be unwelcome, bullying, harassment, or a lack of psychological safety, may contravene these requirements.[17] Expectations that peer supporters engage in unfairly distributed and disproportionate amounts of demeaning menial work are not only a kind of peer support drift, but they may also constitute discriminatory treatment in law.

The common, but inappropriate, expectation that peer supporters should hold a university degree or be registered with a regulatory body as a health professional is another example of peer support drift through the privileging of formal training. This requirement is most often a direct contradiction of the evidence-based practice of peer support being rooted in lived experience rather than educational degrees (Stratford et al., 2019). Such "inflated" credentials may therefore not be "reasonable" or bona fide for the occupation of peer support and may instead constitute a discriminatory restriction of applicant eligibility (Ontario Human Rights Commission, 2008, section IV, 2; also see Adams, 2020).[18] Inequitable provision of training opportunities for peer supporters in comparison to their nondisabled colleagues, unfair compensation, and other common issues peer supporters face in the workplace may also reflect discriminatory treatment.[19]

Peer Support Drift is an Ethical Problem

Ethical problems are problems in decision-making where there is significant uncertainty about what is the good, right, and just thing to do. Oftentimes this uncertainty arises when two or more values conflict and cannot be reconciled or enacted simultaneously. People facing an ethical dilemma must determine which is the best, most ethically acceptable option (or the least bad of bad options) under the circumstances, based on careful deliberation and weighing of values and options.

As depicted in Figure 10, when peer supporters are asked or expected to do something that does not align with peer support values or practice standards and that constitutes a kind of peer support drift, they face a conflict. They may be unable to do what is being requested of them and stay within their peer support role at the same time. They are faced with a difficult decision about what to do. The following quotes illustrate conflicts where peer supporters have felt they cannot uphold two values, loyalties, or interests (see definitions in Figure 11) at the same time.

"The medical model, which is an illness paradigm...conflicts with the healing paradigm of the consumer/survivor movement, and forces the consumer/provider to choose between the paradigms. In so doing, the consumer/provider must choose between the need to continue recovery or the wish to gain rewards from the organization."

(Fisher, 1994, p. 68)

"The peers we spoke to often felt conflicted about how to behave towards their colleagues and perform their job duties. The vulnerability and authenticity they brought to their work often ostracized them from their non-peer colleagues,[20] but upholding standards of professionalism undermined their ability to provide support and connect with clients."

(CMHA, BC Division, 2023a, p. 53)

"I remember, there was a patient who did not like his nurse. And then the team spoke about it, and the general opinion in the room was that you should not be able to change nurse because then everyone would want to. And then I protested! What is most important? I ended up in a situation: should I be collegial or should I be on the patient's side?"

(Peer supporter cited in Wall et al., 2022, p. 6)

"I think to hold onto your values really tightly makes the work more pure, but it can also make the job more distressing at times, especially when you work in organisations that, their values are almost opposite to some of what peer work values are."

(Lived experience worker cited in Edan et al., 2021, p. 3292)

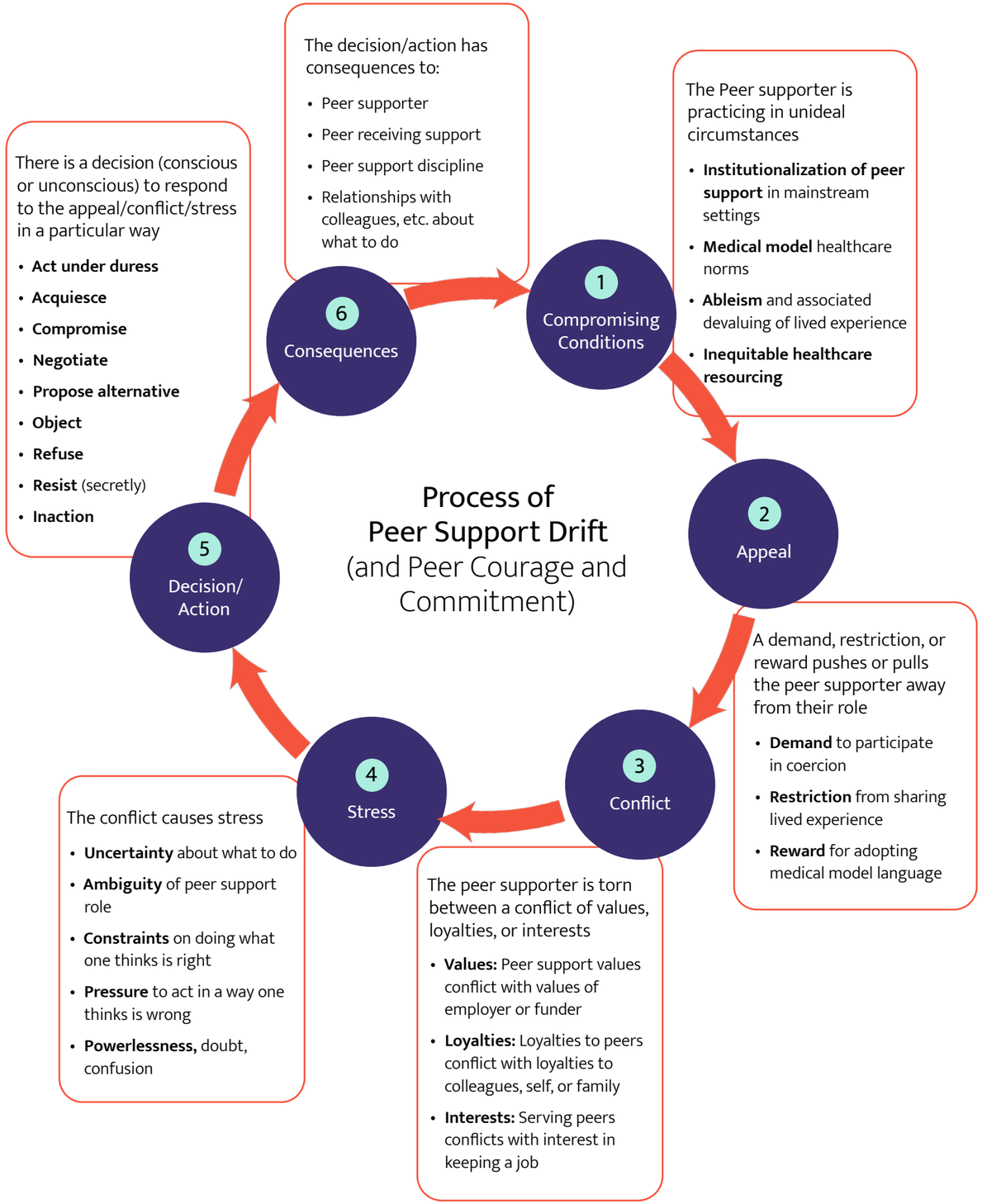


Figure 10. Process of Peer Support Drift

Ethical Issue	Description	Examples
Conflicting Values	Conflict between: • Peer support values and • Values of the psychiatric system, employer, funder, or government May require prioritizing one value over another	Conflict between values of: • Shared power vs. expert power • Social change vs. status quo • Autonomy vs. safety and risk management • Holistic and personalized care vs. cost-effectiveness and standardization
Conflicting Loyalties	Conflict across multiple accountabilities arising from: • Multiple relationships or • Multiple roles that cannot be fully and equally upheld at the same time	Conflict between loyalties to: • Peers and the peer support discipline • Colleagues, organization, employer, funder, self, family
Conflicting Interests	Conflict between two or more interests, where serving one interest means working against another	Conflict between interests in: • Maintaining integrity as a peer supporter vs. keeping one's job • Protecting a trusting relationship with a peer vs. developing a positive relationship with one's non-peer colleagues or supervisor

Figure 11. Definitions of Conflicting Values, Loyalties, and Interests

As peer supporters navigate these conflicts day in and day out, they may slowly, unintentionally, and unconsciously — and often forced by their workplace conditions — begin drifting away from peer support values and standards. Over time, small concessions can become easier and easier to make until a person has altered their course and descended a slippery slope (Kleinman, 2006).

Faced with challenging ethical conflicts, peer supporters can alternatively act with courage and commitment to peer support values. Decision-making within the power structures of healthcare systems is a dynamic process where the right thing to do is often unclear or challenging to implement, and where individuals practice values-aligned peer support one decision at a time (see Sinclair et al., 2023).

8 Peer support drift causes harm to health systems, society, and peer supporters.

Peer support drift is irreconcilable with the peer support values of hope and recovery; empathetic and equal relationships; self-determination; dignity, respect, and social inclusion; integrity, authenticity, and trust; health and wellness; and lifelong learning and personal growth (Peer Support Canada, 2019). Moreover, drifted peer support practice causes significant harm to health systems, society, and peer supporters.

Harms to Health Systems and Society

Loss of Alternative Paradigms

The institutionalization of peer support in mainstream health settings has weakened the discipline's grounding in social movement goals (Scott, 2015), drifted the practice of peer support away from its values and standards, and some might warn, nearly delivered the movement to our "death-by-institution" (Saraswati & Shaw, 2022, p. 172).

Two concepts help explain the ramifications of this loss: The term "cultural imperialism" refers to a form of oppression where a dominant idea is imposed on people, and their own interpretations of their lives are ignored or erased (Young, 1990). A second concept, epistemic (hermeneutical) injustice, refers to the inability to make sense of an experience due to a gap in language and meaning. The powerful psychiatric system perpetuates these forms of violence by promoting deficit-focused understandings of mental illness and addiction that are so powerful they make it very difficult to understand one's experiences in any other way (LeBlanc & Kinsella, 2016).

In contrast, politicized peer support actively challenges the cultural imperialism and epistemic injustice of psychiatry by amplifying alternative non-stigmatizing understandings of mental differences and distress, supporting the freedom to choose from a wide range of approaches to healing and recovery, and protecting the right to control one's body and mind. Peer support plays a vital role in encouraging people to reclaim their voice and ownership of their experiences and to reject dominant perspectives that are harmful or unhelpful to them. Bolstered by social justice values, peer support also encourages collective action to address the structural problems causing social suffering (Usar, 2014).

When peer support drifts from its values, intentions, and focus on social change, begins "mimicking" and "parody[ing] the system that has dehumanised us," and "degenerate[s] to the level of the conventional services" (O'Hagan, 1993, pp. 82-83), we are deprived of these unique possibilities for challenging dominant medical/psychiatric treatment paradigms rooted in colonial, racist, ableist, patriarchal, and heteronormative systems of oppression. We also risk losing generations of peer knowledge and the healing and transformative power of peer communities.

> **"The epic marathon it took to overcome significant barriers, build lived experience roles, and articulate consumer knowledge as a unique discipline in the field of mental health must be esteemed. Otherwise there is a risk services will be robbed of solid consumer perspective and leadership."**
>
> (Victorian Mental Illness Awareness Council and Centre for Psychiatric Nursing, 2018, p. 7)

> **"[S]omething got lost along the road to professionalization. What got lost was a relationship between two people that transcended the roles of counselor and client. What got lost was our deep involvement in the community and in local communities of recovery. What got lost was our recognition of the power of community to heal and sustain people. ...[W]e don't need more agencies or larger agencies, but...we desperately need more community."**
>
> (White, 2003, p. 3)

Loss of Peer and Public Trust

Harms to trust are of significant concern to the peer support discipline because "peer support is impossible to provide without rapport, trust, and respect for the [peer's] agency" (Trans Lifeline, 2020, p. 3; Barrenger et al., 2018). Maintaining trust is even more crucial when peer supporters may have the "ability to establish trust when others may be unable to" (Pauly et al., 2021, p. 4; Shook et al., 2024).

> **"Women [in prisons] often say 'oh you don't know what it is like' and me saying 'actually I do know' makes them open up and trust me in a different way from trusting non-peers."**
>
> (Peer worker cited in Faulkner & Kalathil, 2012, p. 22).

> **"I've heard so many stories of being let down by workers, and workers not being there, and workers not caring, and workers forgetting. I take the time. I have human relatability. It just opens up a more trusting, engaging, and interchangeable relationship."**
>
> (Peer worker cited in Epstein et al., 2023, p. 17)

Building trust with peers and developing a reputation for peer support as a trustworthy discipline and approach requires a solid identity of who we are as peer supporters, what we do, and the value of this work. Peer support drift harms the clarity, consistency, and continuity of this identity, and associated trust and reputation by creating public confusion and misinformation about peer support. Role ambiguity can cause peers to distrust a care provider's ability to provide support (Shook et al., 2024).

> **"[W]hen you're the only peer supporter in a professional team, very often we lose a bit, it's easy to lose your colour. [...] There are always dangers...to keep our authenticity when we work with teams, to not...los[e] our identity."**
>
> (Peer supporter cited in Rebeiro Gruhl et al., 2023, p. 89)

Peer supporters have also warned of peers' expressions of skepticism, fear, and distrust when peer supporters are perceived to be acting like a health professional or with loyalties to professional colleagues. For example, they have identified metaphors of peer supporters as the "pill police," "a wolf in sheep's clothing" (i.e., clothed as a peer but acting as a clinician or arm of the psychiatric system) (Watson, 2020, pp. 137, 141), or as a trickster and rat dishonestly abusing the intimacy of the peer support relationship to "discover [the peer's] secrets" and "rat [them] out" to clinical colleagues (Gamble as cited in Prowse, 2022, p. 76).

Peer support drift towards clinical approaches thus carries a risk that peer supporters will develop a reputation of being just as untrustworthy as other care professionals in the health system (e.g., Winnett, 2022). When this happens, the potential benefits of peer support that depend on a trusting relationship cannot be realized. Peer supporters may also find this loss of credibility and trust highly distressing.

> **"You don't want to come across as professional, you want to come across as somebody that can be trusted, that can be a buddy or at least be trusted, just somebody to get on with, you know. You don't want to come across as a social worker or a [unemployment or sickness benefits] worker or anything else. That's the exact opposite to what peer supporters should be."**
>
> (Ross, as cited in Scott et al., 2011, p. 193)

> **"If they don't trust you, that is the end of it. Just forget it. They will come down, get their gear and go. ...So trust is a very big, a very big issue in NSP [Needle Syringe Program]."**
>
> (Participant 11, as cited in Treloar et al., 2016, p. 142)

> **"Any time I have been in a professional [peer] capacity—what happens without fail is that people start treating me as a professional and as an entity that is different from them... It is really disheartening and an awful feeling. They treat you like the mental health professionals that they have dealt with all their life."**
>
> (N, as cited in Mancini & Lawson, 2009, p. 13)

A lack of role clarity causing or arising from peer support drift can also impact the formation of trust between a peer supporter and their team members, impeding coordination, collaboration, and decision-making (Curnin et al., 2015). Additionally, organizations providing peer support in ways misaligned with the core values of the discipline risk being perceived as untrustworthy partners. These sorts of dynamics can damage vital relationships needed to grow peer support and achieve government goals for greater collaboration in the health sector.

Loss of Unique Opportunities to Address Gaps and Unmet Needs

When peer support drifts from its proper role and begins to duplicate mainstream services, it loses or reduces its unique ability to bridge gaps in the healthcare system, address the unmet needs of marginalized people, and achieve other valued outcomes.

Peer support is regularly characterized as "filling a gap" in the following six domains of mental health and addiction services.[21]

1. **Gaps in access to trusting relationships** with someone who understands (as discussed earlier).
2. **Gaps between services and in service availability:** such as supporting people on waitlists; providing support before, during, after, or instead of other treatment; and addressing gaps between outpatient and emergency services and between the medical system and community services.
3. **Gaps in service accessibility:** such as providing flexible, adaptable services tailored to service user needs; support for minority groups not well understood or served by mainstream services; and lower-cost services more affordable for healthcare budgets.
4. **Gaps in a recovery orientation:** such as encouraging and empowering people whose sense of self and relationships have been disrupted by stigma and discrimination to "recognize that their lives have value, dignity, and worth" (Jozaghi, 2014, p. 6).
5. **Gaps in awareness and advocacy:** such as bringing people together and helping them feel less alone when their struggle is not recognized by society or mainstream services; and collective work to address negative treatment in mainstream services.
6. **Gaps in meaningful work opportunities.**

Peer support is also described as addressing "unmet needs" like those related to easing loneliness and social isolation, enhancing quality of life, reducing suicide and drug poisoning, and mitigating other negative health effects of living in an oppressive society (Boucher et al., 2022; Fortuna et al., 2019; Kia et al., 2021, 2023). When peer support drifts away from its unique role, these opportunities to fill gaps and address unmet needs are forfeit.

Additionally, the literature tells us that people value peer support because it counteracts the powerlessness of the patient role through normalizing, nontreatment-based human relationships. When peer support is fundamentally altered and practiced in a clinical way, it is ineffective in realizing these outcomes (Gillard, 2019; Standing Senate Committee on Social Affairs, Science and Technology, 2006; White et al., 2020). Peer supporters who drift into an authoritarian, rigid approach or seek to impose a particular view of recovery, for example, are unlikely to be perceived by service users as helpful (Ogundipe et al., 2019).

Lost opportunities to fill gaps and meet unaddressed needs are likely to have the most devastating effect on those who are most marginalized and poorly served by mainstream mental health services, such as those who fought to create peer-run alternatives in the first place (Epstein et al., 2023; Mood Disorders Society of Canada, 2022; Standing Senate Committee on Social Affairs, Science and Technology, 2006).

Harms to Peer Supporters

Peer support drift harms peer supporters by interfering with core dimensions of well-being, recovery, and social inclusion, such as those highlighted by the CHIME framework (see Bird et al., 2014).

Dimension	Harms to Peer Supporters
Connectedness	• Harms to relationships with peers and colleagues • Isolation on interprofessional teams • Alienation in the workplace
Hope and Optimism	• Loss of hope for peers they are supporting • Pessimism in the future of peer support and the consumer/survivor movement • Discouragement around the possibility for institutional change • Limited support for career aspirations
Identity	• Internalization of stigma • Shame in the peer support identity • Role ambiguity and uncertainty
Meaning and Purpose	• Lived experience interpretations suppressed by psychiatric interpretations • Expectations to engage in demeaning work without meaning • Blocked from participating in the aspects of peer support that bring most meaning and purpose • Confusion and uncertainty over one's purpose (in the workplace, in life) or barriers fulfilling one's purpose • Lack of financial and social resources (e.g., income, health benefits, vacation pay, respect, equal colleagues) to build one's life
Empowerment	• Powerlessness within the workplace • Limited recognition, cultivation, and use of peer supporter strengths and capabilities • Little opportunity to voice and have experiential knowledge heard

Figure 12. Impact of Peer Support Drift on CHIME Dimensions

The moral injury and waste of capabilities perpetuated by peer support drift can have particularly detrimental effects, as elaborated next.

Moral Injury

Peer supporters can experience lasting moral distress and injury when they feel betrayed by an organizational culture that disrespects peer support, pressured to transgress their deeply held values, or prevented from doing what they feel is right. This moral distress may include guilt, remorse, shame, and self-blame. For example, peer supporters have described regret over their efforts to integrate paid peer support roles into mainstream systems when role adherence to peer support values was compromised by clinicians and administrators and ultimately not maintained in practice (Penney & Prescott, 2016).

Peer supporters may find it particularly morally injurious and intolerable to drift into clinical tasks like participation in coercion where they are complicit in the very same harms that they survived as a service user (Foglesong et al., 2022; Forbes et al., 2022; Mamdani et al., 2021; Sinclair et al., 2023; Victorian Mental Illness Awareness Council and Centre for Psychiatric Nursing, 2018).

"I left [a peer support position on an acute inpatient ward] because I had reached a point where I felt I could no longer work in an environment which compromised my own values, and the values of peer support. ...I asked myself many times whether I would be able to, or even whether my conscience would allow me to, work within [the psychiatric system]... [W]ould I feel that I was condoning a system that had essentially harmed me? ...[T]o work within this system, to be implicitly endorsing this culture was ultimately too much of a compromise."

(Irwin, 2017, pp. 153-154)

"I have been thinking most days about how this [peer support] job is killing me. ...[I]t feels like every day it is reaching into my soul and clawing little chunks away. This system is taking something from me that has been so hard fought, something so meaningful, and it just plucks it out."

(Watson, 2020, p. 226)

"[Addiction peer supporters] are suffering from increased disenchantment in their professional lives. They regularly lament that it is getting harder and harder to feel good about what they are doing. ...Many are referring to the field's crisis as spiritual in nature—a crisis in values."

(White, 2001, p. 10)

Institutionalized disregard of their unique knowledge and role may also negatively impact peer supporters' sense of self-respect and moral worth and contribute to a feeling of powerlessness around living their values. Internalization of oppression in the workplace can cause further drift in peer support practices, such as through decreased resistance to colleagues' deficit-focused medical language and gradual acceptance and application of pathologizing views that conflict with peer support's recovery orientation (Deegan, 2004).

Waste of Capabilities

Peer support drift results in the exploitation of peer supporters and the underdevelopment and waste of their unique capabilities. For example, the targeted allocation of menial work to peer supporters treats them as only valuable for their labour and not as persons who deserve dignity and respect. This inequitable task distribution also blocks peer supporters from using and developing their capabilities while nondisabled colleagues are released to engage in more meaningful and higher-status work (Young, 1990).

Peer supporters' capabilities are further undermined by the devaluing of experiential knowledge, and the emotional and physical exhaustion from poor working conditions. These dynamics often compromise well-being, cause alienation and disengagement in the workplace, and contribute to burnout, employee turnover, and departure from the peer support movement (Forbes et al., 2022; Irwin, 2017; Mamdani et al., 2021).

"Unfortunately, it's more common that peer workers in these [mainstream mental health] settings feel over-controlled and under-respected by their professional and management colleagues. These organizations often have other priorities so the peer support part of the service may be neglected. Some said...professionals tended to see peer specialists as cheap labour who lessened their own workloads, rather than a separate form of service delivery."

(Cyr et al., 2010, p. 82)

"I've seen [peer supporters] get used up and sucked dry by organizations."

(L. Michaud as cited in Michaud et al., 2016, p. 193)

"I was about to become burned out...because it took such a toll on me in my role that I would suddenly wear [white hospital staff] clothes. It became a bigger thing than other staff understood."

(Peer supporter cited in Wall et al., 2022, p. 349)

"It feels like peer support is being set up to fail. We are so small as to be powerless, tasked with co-producing a culture change, an impossible venture. How can an ant coproduce anything with a killer whale? They don't even live in the same reality. The ants would just fucking drown."

(Watson, 2020, p. 138)

It is unfair for peer supporters to bear this disproportionate burden of moral and emotional stress and the occupational health and safety risks from poorly supported employment roles. "It would be unthinkable for another sector of healthcare workers to be expected to work under these conditions" (Mood Disorders Society of Canada, 2022, p. 15). Workplaces further this injustice when they fail to take responsibility for working conditions and instead attribute a peer supporter's occupational distress to an internal conception of illness or personal lack of self-care (Epstein et al., 2023).

These harms affect peer supporters as individuals and as a group and impact their ability to provide peer support and contribute to health system transformation. Ongoing disrespect of peer supporters also undermines national efforts to destigmatize mental health and addictions and bring about the inclusion of people with lived experience in the workplace and society at large.

9 Peer supporters experience the problem of peer support drift in different ways.

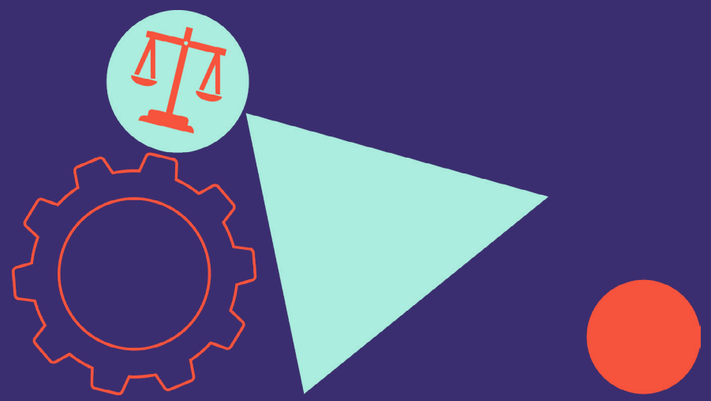
While peer support drift is not a problem primarily caused or resolved by individuals, it does impact individual peer supporters differently. The resources peer supporters have access to, the barriers they face in the workplace, and their positionality result in different strategies, possibilities, and challenges for navigating peer support drift and advocating for the proper scope of the peer support role (see CMHA, BC Division, 2023ab).

For example, individual peer supporters may be more likely to drift into a clinical role when they are unaware of the social movement roots of peer support, have had more positive encounters with the mental health system, sincerely believe in the medical model, and consequently notice and experience fewer conflicts between mainstream and peer approaches (Penney & Prescot, 2016).

Organizational peer support drift in the form of inflated job requirements is more likely to benefit peers with postsecondary training and credentials, and to block those most impacted by systems of oppression from gaining access to peer support positions (Mamdani et al., 2021; Michaud et al., 2016). Furthermore, the devaluing of lived experiences related to mental health and/or addictions is intimately entangled with the racism that Indigenous, Black, and racialized peer supporters often face in the workplace (Epstein et al., 2023; Fuentes et al., 2023). Peer supporters are at greater risk of burnout when they are also isolated as the sole racialized person or provider of culturally specific support on their team (Lo & Chung, 2005).

Any discussion of peer support drift therefore needs to grapple with differential impacts and experiences. We have much work to do to move beyond the language of "peer support drift" to understand how these practices not only reflect drift from peer support values, but the enactment of colonial, racist, ableist, patriarchal, and heterosexist approaches to care.

Part 3: Recommendations for Addressing Peer Support Drift and Protecting Peer Support Values and Standards



10 Addressing the systemic problem of peer support drift requires collective, properly resourced prevention and intervention led by people with lived experience.

Peer support drift is a systemic problem that will not be solved by further professionalization. Urgent and collective action, culture change, and equitable resource allocation is required to address and prevent drift and enable peer supporters to practice with integrity.

This work must be peer-led, with appropriate support and resources from government and health partners. Although peer supporters did not create the problem of peer support drift, we are best positioned to develop and direct effective responses to it.

The recommendations that follow, aimed at the five levels of (I) government and other sponsors of peer support, (II) the peer support discipline, (III) peer support initiatives, (IV) non-peer organizational and individual allies, and (V) peer supporters, urge us all to mobilize the position statement within our specific realms of influence.

Recommendations for Government and Other Sponsors of Peer Support

Consumer/survivor leaders in Ontario have been calling on the government for over 25 years for resources and policy change to support peer support in mental health and addictions.[22] While peer support has evolved over this time, and resources for some aspects have increased, many recommendations remain unaddressed. Then, like now, the "overriding recommendation is that action must follow this report" (O'Hagan et al., 2009, p. 15).

The recommendations below must be acted on in full to address peer support drift. All other non-governmental funders and sponsors of peer support should likewise seek to sustain peer support initiatives in alignment with this statement.

1. **End discrimination against lived experience organizations and ensure equitable funding of consumer/survivor, peer-led, and peer support initiatives** (see CMHA et al., 2005; Cyr et al., 2010; TaylorNewberry Consulting, 2014).

a. Standardize, centralize, and increase the base operational funding model for community-based peer support organizations to support a universal standard of care across the province, and to reduce the burden and risk of peer support drift caused by project-based funding and funding dependent on annual assessment (OPDI, 2021; PeerWorks, 2022b).

b. Ensure First Nations, Métis, and Inuit communities hold funding for Indigenous-led and community-based services so they control what peer support grounded in Indigenous ways of knowing and healing should look like for them (CMHA, BC Division, 2023a).

c. To aid accountability, provide a breakdown of the Government of Ontario's budget for mental health services. Transparently disclose the amount of funding granted to autonomous consumer/survivor and peer-led initiatives and other community-based peer support organizations compared to hospital-based peer support programs.

d. Ensure funding for peer support is being put towards initiatives that align with the definition, core values, role, and attributes of peer support as characterized in this statement. Help us understand how these decisions are made and what vetting processes are in place to ensure that peer support funding is not being misallocated or allocated to organizations or programs that contribute to the harms of peer support drift identified within this position statement.

e. Ensure that new funding programs offer adequate time and flexibility for peer-led initiatives to submit proposals that best meet member needs and maintain integrity with peer support values and standards. Without time and flexibility, there is a significant risk of forcing rushed and unequal partnerships or programming that distracts peer support from its core values and special activities. Develop a dedicated funding stream for peer-led peer support initiatives that incentivizes collaboration rather than internal competition for limited resources (Mood Disorders Association of Canada, 2022).

f. Provide funding for peer-led provincial and national infrastructure that supports the peer support discipline (e.g., government relations and policy advising, organizational development, creation of practice guidelines, training and professional development, research and evaluation, knowledge mobilization and dissemination, communities of practice). Ensure that this funding includes dedicated resources for systemic advocacy and for peer support workers and initiatives to network, strategize, and build solidarity and strategic directions for systems-level change (Mental Health Commission of Canada, 2012; Nelson et al., 2008; O'Hagan et al., 2009).

2. **Develop stronger policy to support the equitable integration of peer supporters and values-aligned peer support into health and social welfare systems.**

a. Explore and enact systemic strategies to improve peer supporters' working conditions. In doing so, recognize peer supporters as a group of workers who make tremendous contributions to society yet are often precariously employed; disproportionately vulnerable to low pay, disrespect, and human rights and labour law infringement in employment; and who face barriers accessing existing legal remedies (Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities, 2019).[23]

b. Commission and support peer-led creation of a peer support workforce development framework, strategy, and action plan (e.g., Byrne et al., 2021; Government of Western Australia Mental Health Commission, 2022b; Te Pou, 2021).

c. Collaborate with the peer support sector to revise accountability structures, evaluation frameworks, and data collection and reporting requirements to align with peer support values (CMHA et al., 2005; O'Hagan et al., 2009). Refer back to the Senate's 2006 "Out of the Shadows at Last" report on transforming mental health and addiction services in Canada to better appreciate the concerns and needs of peer support initiatives with respect to funding and accountability (Standing Senate Committee on Social Affairs, Science and Technology, 2006, pp. 227–247).

d. Ensure that the interrelated forms of mental health peer support and addiction/harm reduction peer support are addressed together rather than separately. For example, the development of any policy or standards for one branch ought to consider the other one as well.

3. Support the independence and influence of peer-led initiatives and lived experience leadership in the health system.

a. Actively support and enable peer support initiatives to strengthen their independent voice and move back to organizational autonomy with a lived experience board and governance model (OPDI, 2021).

b. Ensure that lived experience representatives from independent peer support initiatives who reflect diverse identities/social locations are meaningfully involved in healthcare decision-making, governance, accreditation, monitoring, evaluation, and advisory bodies, and take up positions at all levels of the health system (Mental Health Commission of Canada, 2012; OPDI, 2009).

c. Ensure that any further professionalization of peer support (e.g., certification of peer supporters) is led by peer-led organizations, mitigates barriers to participation (e.g., cost, prerequisites), does not aggravate inequity between differently positioned peer supporters, and results in meaningful benefit to peer communities.

d. Require and embed peer-led training into onboarding for relevant government officials, as well as health professions education programs and requirements for continuing professional development (Rebeiro Gruhl et al., 2023). This training should cover the history and values of peer support, the peer support role, the value of knowledge from lived experience, respectful collaboration with peer support initiatives and lived experience leaders, and challenging ableism. Peer support has been funded by the Government of Ontario for over 30 years, so there is no excuse for decision-making based on misunderstanding the history and values of the discipline.

Recommendations for the Discipline of Peer Support

These recommendations are for professional associations like Peer Support Canada and PeerWorks in Ontario. They also apply to other leaders who represent the discipline of peer support at decision-making tables, speak on the discipline's behalf, publish peer support knowledge, and/or who have access to resources, authority, audiences, or communication channels to inform, consult, mobilize, train, credential, and/or otherwise support peer supporters. Of course, as discussed, to enact these recommendations, appropriate funding and resources are required.

4. Continue to mobilize the discipline through consultation, collaboration, and collective decision-making to strengthen peer support and respond to peer support drift.

a. Validate the relevance of this position statement for peer support practice in other jurisdictions across Canada and revise it through consultation.

b. Continue working towards developing a common purpose, shared understanding, and consistent messaging about the peer support role across the province and country. This will require ongoing effort to build meaningful relationships with groups under-represented in (and by) the discipline (Kalathil, 2013). In pursuit of disciplinary consensus, recognize, invite, engage with, learn from, acknowledge, and account for dissenting perspectives.

c. Raise the profile and public understanding of peer support (especially less visible and recognized forms) such as through nationally and provincially coordinated annual weeks to celebrate the discipline and opportunities to document and share peer support group histories and work.

d. Continue facilitating opportunities for peer supporters to participate in deliberations regarding the future of the discipline, such as work to develop professional standards, guidelines, or position statements (e.g., Foglesong et al., 2022; Kirby & Simpson, 2012).

e. Bring leaders of peer support programs together in advance of them signing funding or other contracts to support collective advocacy and decision-making with respect to contract terms and reporting requirements. Pool knowledge about successful negotiation strategies with government and other funders to align contracts with peer support values.

f. Encourage and support further research on peer support drift to better understand the problem, confirm priorities for action, and evaluate the effectiveness of interventions. Prioritize engagement with peer supporters facing the greatest precarity, fewest resources, and who are under-represented in the discipline to ensure understandings of and responses to peer support drift are useful to those most impacted.

g. Engage in consultation, discussion, learning, and action to acknowledge, understand, and address racism in peer support work and broader consumer/survivor and harm reduction movements (Epstein et al., 2023; Gorman et al., 2023; Kalathil, 2013). Recognize racism and other forms of inequities within the discipline as an example of drift from peer support values.

h. Explore further opportunities for collective mobilization and action within existing legal and political infrastructure.[24]

i. Build and enhance partnerships with peer support initiatives that are grassroots, unfunded, and/or from sectors and communities beyond mental health and addictions to extend the strength and reach of collective advocacy (e.g., Holloway et al., 2023; Johnson et al., 2023).

j. Learn from the ways that the institutionalization of peer support and struggle against peer support drift can bring us into relationship with the related struggles of other marginalized groups and social movements. Prioritize greater collaboration and solidarity to exchange knowledge and address shared concerns.[25]

5. Review and enhance peer support standards to guide values-aligned practice.

a. Build on existing peer support guidance documents to develop a scope of practice for mental health and addiction peer support in Canada.

b. Update the current guiding standards for peer support (Peer Support Accreditation and Certification Canada, 2016; Peer Support Canada, 2019; Sunderland & Mishkin, 2013; Support House: Centre for Innovation in Peer Support, 2022) so that they more explicitly and comprehensively discuss competencies in advocacy, social justice work, responsibilities with respect to the Truth and Reconciliation Commission of Canada's (2015) Calls to Action, and knowledge of social movement histories.

c. Collaborate to learn more about the values that peer supporters bring to their practice from other traditions of peer support, mutual aid, community care, and civil rights organizing beyond those dominant in the mental health and addiction sector (e.g., Indigenous worldviews, Black history, disability justice). Revise national peer support values to reflect what is learned.

d. Review, nuance, and offer guidance on interpreting the peer support competencies within a context of ableism. For example, some of the expected competencies (like "strives to make others feel comfortable" or "compromises when needed") (Peer Support Accreditation and Certification Canada, 2016, p. 12) are intended to focus on supporting peers within an ideal, equitable workplace. They should not be inappropriately taken as instruction for how peer supporters ought to respond to the disrespect of colleagues or organizational expectations to drift beyond their role. Critical analysis of the mental health system and the mistreatment of peer supporters is consistent with the strengths and recovery focus of peer support and is necessary for practicing in alignment with the peer support value of social inclusion (Sinclair et al., 2022).

6. Develop social justice-focused educational resources and professional development opportunities for those in varied roles across the peer support discipline.

a. Support initiatives that take a critical approach to uncovering, interpreting, documenting, and sharing social movement and community histories that ground peer support values. For example, learn more about peer support practices in Indigenous sovereignty and civil rights movements that informed consumer/survivor movements. Make visible the contributions of groups commonly under-represented in dominant white, Eurocentric C/S/X movement histories.[26] Integrate this knowledge into educational resources for peer supporters.

b. Recognizing that the problem of peer support drift is only the latest example of how lived experience initiatives "have been taken up by and then diluted or distorted by well-intended but misguided mental health systems" (Stratford et al., 2019, p. 629), develop educational resources that aid peer supporters in recognizing and creatively and vigilantly resisting processes of co-optation. To understand and confront co-optation, we also need to better understand systems and operations of power and oppression in peer support work.

c. Provide guidance on recruiting and supporting peer supporters from under-represented groups and lived experiences. A diverse group of peer supporters in every location where peer support is practiced has a greater chance of keeping peer support politicized through constant learning and unlearning from each other (Morgen, 1986).

d. Envision and support creative forms of career advancement for peer supporters so that they can flourish and grow as peer support practitioners, program managers, and leaders rather than feeling that the only way to develop themselves is to drift into a clinical role and/or complete a postsecondary credential.

e. Enhance educational resources and professional development opportunities for peer supporters across contexts and at all career stages, particularly those that support them in resisting peer support drift and engaging in advocacy and social justice work. For example, convert material from this position statement into trainings, tools, and topics for a community of practice; share examples of how peer supporters can politicize their work and engage in everyday acts of resistance; and offer strategies for responding to microaggressions, ableism, and disrespect in the workplace (see CMHA, BC Division, 2023b; Sinclair, 2018; Smith, 2012; Yu & Mandell, 2015). In addition to general resources, collaborate to develop meaningful opportunities for learning and community among peer supporters who share other identities/affinities in common (e.g., Indigenous, Black, racialized, 2SLGBTQIA+, disabled, and youth peer supporters; see Native Youth Sexual Health Network, 2021; Public Health Ontario, 2023).

f. Explore and build further connections between the disciplines of peer support and Mad Studies. These are two interrelated (yet oftentimes disconnected) expressions of the contemporary consumer/survivor movement that face similar challenges from institutionalization into healthcare and the university (Armstrong & LeFrançois, 2021; Reville, 2021; Russo, 2021). Further connections between peer support and Mad Studies can help in developing educational resources, envisioning pathways for peer support career progression, and generating critical peer support knowledge, among other possibilities.

g. Develop guidance for peer supporters engaged in new and emerging areas of practice (e.g., supervision expectations for those in private practice).

Recommendations for Peer Support Initiatives, Leaders, and Supervisors

These recommendations are for those responsible for directing, managing, or developing consumer/survivor initiatives, peer-run programs, or peer support programs within mainstream mental health and addiction services, as well as those supervising peer supporters.

7. Lead peer support programs in alignment with the discipline's values, standards, and best practices.

a. Further develop pathways into leadership roles for peer supporters so that all aspects of peer support program oversight, development, operations, and evaluation are led by people with lived experience in alignment with peer support values. No peer support program should be managed by a clinician. Wherever possible, hire internally through supported succession planning. Guard against the creation of leadership positions in peer support that require degrees and certifications (Stamou, 2014).

b. Enact best practices for fostering equitable and non-discriminatory workplaces that comply with Ontario's Human Rights Code (see Ontario Human Rights Commission, 2008, 2012, 2016). This should include design of peer support job postings with only bona fide requirements and work to assess and equalize power across staff roles (see CMHA, BC Division, 2023b).

c. Prioritize recruitment of peer supporters from communities and with lived experiences that are under-represented in the discipline and organization and actively work to support and advance the knowledge, perspectives, ideas, and initiatives they bring to peer support.

d. Demonstrate organizational commitment to peer supporters through the implementation of effective organizational strategies and cultivation of a supportive organizational culture (see Government of Western Australia Mental Health Commission, 2022b, p. 37). Ensure best practices in training, integration, task assignments, and compensation of peer supporters (e.g., see CMHA, BC Division, 2023bc; Cramp et al., 2017; Hopkins & Gremmen, 2022a; Peer Support Accreditation and Certification Canada, 2016; Repper, 2022; Sunderland & Mishkin, 2013).

e. Ensure that all peer supporters are supervised by a person with lived and peer support experience who enacts best practices in peer support supervision (see Phillips, 2021; Phillips et al., 2021; Victorian Mental Illness Awareness Council and Centre for Psychiatric Nursing, 2018).

8. Continue advocating for the integrity and politicization of peer support and resisting peer support drift.

a. Participate in regional, provincial, and national efforts to mobilize the peer support discipline as discussed in recommendation 4. Offer paid time for peer supporters to do so as well.

b. Build and strengthen relationships with the elected officials in your jurisdiction to cultivate an understanding of and support for values-aligned peer support.

c. Where applicable, endeavour to make organizational decisions in consultation with other peer support program leaders, recognizing the potential impact of your decision-making on other initiatives. For example, if you accept the terms of a funding contract or reporting requirement, other peer support programs may be in a much more challenging position to resist or refuse these same terms. Get together with other peer support program leaders to discuss (and potentially request revisions to) contracts before signing them. Advocate for the collective of peer support programs, not only the sustainability or success of your own.

d. Walk away from a partnership or funding opportunity if it will mean compromising too much, token inclusion, or other significant harm without sufficient benefit.

e. Refuse to create or manage a peer support program that does not protect the core values and standards of peer support, or that otherwise contributes to peer support drift. Instead, help funders/sponsors/partners understand how such programs are not aligned with best practices in peer support.

f. Rename programs and role titles that are not appropriately called peer support based on the definitions in this statement, and support affected employees in any role transitions.

g. Remove inappropriate barriers to peer support positions (e.g., in job postings, selection criteria, etc.) like education credentials, police record checks, or abstinence.[27] Ensure that peer support role titles are not differentiated based on a person's educational background.

Recommendations for Non-Peer Organizational and Individual Allies

As protecting the integrity of peer support is a collective endeavor, the solidarity of allied organizations (with and without legitimate peer support programs) and individuals (i.e., interprofessional colleagues and researchers) is of tremendous importance.

9. Advocate for organizational decisions and actions that affirm the value of peer support.

a. Use your legitimacy and influence to advocate for greater resourcing, respect, and security of precarious peer support programs and workers. For example, seek appropriate compensation for peer supporters and pay equity across community and hospital peer support roles.

b. Work to ensure people with peer support experience and lived experience of mental health/addiction concerns and other forms of social marginalization (e.g., Indigenous, Black, racialized, 2SLGBTQIA+, and disabled people) have real power to transform the mental health and addiction system. Resource peers to create meaningful peer-led positions at all levels that are appropriately compensated and carry influential weight. Embrace changes advanced by people with lived experience. To enable this work, consider developing a strategy (relevant to your realm of influence or organization) for supporting peer supporters and other employees with lived experience.[28] Guard against habits of only recruiting people with lived experience who otherwise carry significant privilege and reflect the dominant power structure in place (Kalathil, 2013).

c. Ensure any funding received for the provision of peer support is used to support values-aligned peer support as articulated in this statement.

d. Ensure requests to partner with peer support workers or initiatives are respectful of their values, priorities, time, energy, and ways of working and do not expect their adoption of mainstream approaches (Jones, 2009).

e. If your organization is thinking about introducing or expanding a peer support program, connect with local peer-run initiatives to negotiate the secondment of their staff. This type of partnership can help flow resources to poorly funded initiatives and protect against a "brain drain" of peer supporters leaving small community organizations for better supported roles in large health systems.

f. Reclassify role titles that are inaccurately labelled peer support roles.

g. Promote the stories and work of peer support and other lived experience initiatives by ensuring they are frequently and accurately amplified in organizational communications.

10. Meaningfully collaborate with peer support colleagues by understanding and respecting their unique role and expertise.

a. Advocate for the integrity of the peer support role within your spheres of influence and intervene on manifestations of ableism that undermine peer supporters.

b. Ensure interprofessional colleagues of peer supporters receive training and ongoing professional development to understand and protect the unique peer support role.

c. Respect the core values and activities, boundaries, confidentiality practices, non-clinical language use, and recovery orientation of peer supporters by not asking or expecting them to adopt clinical approaches or engage in other tasks inappropriate for their role.

d. Respect the lived knowledge and expertise that peer supporters bring to their work by treating them as colleagues and equals. Refrain from expecting peer supporters to take on illegitimate, unfair, inequitable, disproportionate, and/or unsafe menial work.

e. Accurately explain the nature and value of peer support to prospective clients and make appropriate referrals to peer support programs (i.e., do not send people to peer support for "counselling").

f. Ensure any peer support knowledge generation or dissemination entails meaningful collaboration with peer supporters.

Recommendations for Peer Supporters

Peer support values of acting with integrity, maintaining public confidence in peer support, and engaging in lifelong learning (Peer Support Certification and Accreditation Canada, 2016) encourage all peer supporters to learn more about what we can do to support ourselves and our colleagues in resisting peer support drift. Although drift is a systemic problem that requires collective action, and many peer supporters face constraints on our ability to act, we also have some level of agency (Sinclair, 2018). The following recommendations identify tangible steps we can take to fulfill our professional responsibilities to the discipline.

11. Participate in peer support community, advocacy, and social justice work to politicize peer support practice and resist drift from values and standards.

a. As peer support drift, and the situations that cause it, is stressful, regularly participate in peer support community and professional development opportunities (e.g., peer support training, communities of practice) to gain confidence, company, feedback, and support in maintaining peer support values and avoiding peer support drift.

b. Use this position statement as a tool to advocate for the appropriate peer support role and against inappropriate demands or expectations that contribute to peer support drift.

c. Join and participate in PeerWorks or another professional association of and for peer supporters to contribute to collective advocacy for peer support.

d. Engage in ongoing learning about (and participation in) the histories of consumer/survivor, drug user, Indigenous sovereignty, civil rights, feminist, 2SLGBTQIA+, disability, and other social movements, and consider how their strategies, activities, and demands can ground your peer support practice.

e. Where possible, keep your peer support practice politicized by contributing to advocacy efforts relevant to the lives of your colleagues and the people you support. As Kalathil (2013) reminds us, mental health/addiction is only one aspect of people's lives so working to change mental health services has to be linked with work to address inequities in education, income, housing, citizenship rights, and other social determinants of health.

f. Where possible, explore opportunities to experience grassroots, informal mutual aid to participate in and receive reciprocal support, appreciate and preserve this alternative to increasingly formalized peer support, and inspire ideas for fostering less structured community building within your peer support role (see Piepzna-Samarasinha, 2018; Spade, 2020).

g. Back up your peer support colleagues, particularly those who may be new to peer support, are in more precarious positions, and/or face greater barriers to being listened to and respected in the workplace. Those with greater access to power and privilege have greater duties to use it to support the peer support discipline.

12. Pay attention for and address situations and attitudes that can contribute to peer support drift.

a. Respect peer support as a serious vocation and end in itself, not as a "phase," a temporary opportunity to "gain experience," or a "steppingstone" to a perceived higher status and more valued role (like successive training and drift into a clinical role). Peer support can be a meaningful career for the duration of one's life, particularly when it is resourced, supported, and offers opportunities for learning and advancement as recommended in this statement.

b. If you have participated in any clinical training or postsecondary education that values learned over lived experience, commit to unlearning incongruent ideas, values, and norms you have absorbed from those spaces that can interfere with your ability to practice peer support in alignment with its values and standards.

c. If you are not appropriately trained and supported to conduct peer support with requisite skills, you may be harmed by practicing the role or put peers at risk of harm or reduced benefit. Ensure you are practicing with proper supervision. Speak with a peer support association like PeerWorks or Peer Support Canada if you need assistance advocating for proper support.

d. Where possible, avoid dual roles where you are expected to carry out peer support as well as another function (like case management) that conflicts with peer support values. Ensure any time allotted for peer support is protected and used to practice peer support in alignment with its values and standards.

e. Be cautious about judging other peer supporters as "drifted" or "co-opted" or perceiving yourself as practicing "authentically" and immune to peer support drift. Such attitudes can cause harm through a lack of awareness of privilege or the messy dynamics of drift in everyday practice (Sinclair et al., 2023). They also contribute to lateral violence where we turn on each other rather than collectively address systemic inequities. Peer support is a collective practice. When any one of us struggles, we all struggle (see CMHA, BC Division, 2023a, p. 38).

f. Reflect on your personal interests and loyalties and how these may at times conflict with your protection of the interests of the peer support discipline (e.g., personal interests in keeping a job, getting a promotion or pay increase, being well-liked by non-peer colleagues; loyalty to those who depend on you financially). Stay attentive to ways these personal interests pose a risk of peer support drift.

g. If you feel you are struggling, unsatisfied, discouraged, or burning out in your peer support role, and/or drifting away from peer support values and standards, seek out a peer support community of practice or trusted colleague/mentor to explore what is happening for you. Identify actions you might take to reestablish the parameters of your role and access the support you need and deserve.

h. If you are finding the peer support role as articulated in this position statement no longer aligns with your personal/professional identity or goals, take steps to explore alternative career paths that interest you and better support your learning and growth. When possible, move on from your peer support role and support the discipline of peer support from another position.

Endnotes

1. This synthesis and organization of information was inspired by the methodology of concept analysis (see Dennis, 2003).

2. There are several important nuances to this statement. First, these movements have a much longer history. Second, scholars have suggested that peer-led organizations emerged from (at least) two different movements: One focused on non-oppositional self-help/mutual aid complementary to the mental health system. The other was the social movement for the liberation of psychiatric survivors, which arose to challenge abuse and mistreatment of psychiatric patients (Nelson et al., 2008; Scott, 2015). We see remnants of this history today with some peer support initiatives rooting themselves in advocacy goals more than others.

   Third, scholars are drawing attention to how 1970s C/S/X movements learned (and some have argued, co-opted) peer support practices from civil rights and Indigenous sovereignty movements (for examples of 1970s mutual aid in these communities see Harper, 1979, 1988; Howard-Bobiwash, 2003; Maracle, 2018; Sanderson & Howard-Bobiwash, 1997; Krouse & Howard, 2009; Maxwell, 2009; Schalk, 2022; Shakur & Trinidad, 2022; Wildflower Alliance, 2024). This history of cross-movement learning has been obscured in dominant white C/S/X movement accounts (Epstein et al., 2023; Sinclair et al., 2023; Stephen & Hunter-Young, 2020).

3. See Bennett et al., 2011; Boyd et al., 2009; Curtis, 2004; Mold & Berridge, 2010; Shakur & Trinidad, 2022; Smith, 2012, 2016; Tula, 2022.

4. See Boschma & Devane, 2019; Campbell, 2005; Chamberlin, 1978; Jozaghi, 2014; Mold & Berridge, 2010; Toronto Drug Strategy Advisory Committee, 2005; Weitz, 1984. This included the funding of culturally specific initiatives like the Chinese-Southeast Asian Consumer/Survivor Self-help Centre (C-SSAC), a consumer-run social recreation program (Lo & Chung, 2005). Importantly, initial government funding contracts with Ontario's Consumer/Survivor Development Initiative (now known as PeerWorks) restricted the use of any funding for the delivery of traditional service models with client-provider roles and hierarchies (Trainor et al., 1997).

5. Note that people with lived experience of mental health and/or addiction concerns have been hired by services (in comparatively small numbers) to support their peers since the late 18th century (see Government of Western Australia Mental Health Commission, 2022b; Stratford et al., 2019; White, 2000a).

6. See National Association of Peer Supporters, 2013; Peer Support Accreditation and Certification Canada, 2016; Peer Support Canada, 2019; Stratford et al., 2019; World Health Organization, 2019.

7. For example, healthcare legislation authorizes certain health professions to label a person's experience with a diagnosis, prescribe mind-altering drugs, and suspend a person's freedom and liberties through detention in a hospital against their will or finding them incapable of making their own medical decisions. These powers can have tremendous effects on the lives of people with mental health and addiction concerns.

8. For further commentary on the emergence of the term "people with lived or living experience" in the mental health and addiction context, see National Consumer Panel, ca. 2011; Penney & Prescott, 2016; Reville & Church, 2012; Voronka, 2016.

9. Our argument here is that the title "peer support" should only be used for roles focused on peer support. We are not, however, proposing that all peer support positions must carry this title as there are circumstances where this may be undesired, disrespectful, or culturally inappropriate. For example, some people who use their lived experience to support others in overdose response settings have expressed that the title "peer" is stigmatizing and derogatory because it defines people by their history of substance use, sets them apart from society, and does not adequately recognize their knowledge and contributions (Mamdani et al., 2021; also see Epstein et al, 2023).

10. See Alberta & Ploski, 2014; Brown & Stastny, 2016; Ellison, 2012; Foglesong et al., 2022; Government of Western Australia Mental Health Commission, 2022a; National Association of Peer Supporters, 2019; O'Hagan, 1993; Penney & Prescott, 2016; Phillips, 2021; Rebeiro Gruhl et al., 2023; SAMHSA, 2022; Usar, 2014; WHO, 2019.

11. As a verb (action), drift can mean: "to move slowly, especially as a result of outside forces, with no control over direction," "to be carried along…by the force of circumstances," "a gradual shift in attitude, opinion, or position," "to move along a line of least resistance," "to become carried along subject to no guidance or control," "to vary from a set course," or "to wander aimlessly." As a noun (thing), drift can refer to "a deviation from a true representation" and "the act of driving something along" (Cambridge Dictionary, 2023; Dictionary.com, 2023; Merriam-Webster Dictionary, 2023). Each of these definitions highlights important features of what drift can entail in the peer support context.

12. See Standing Senate Committee on Social Affairs, Science and Technology, 2006, p. 242; O'Hagan et al., 2009, p. 26; Sunderland et al., 2013, p. 18; TaylorNewberry Consulting, 2014; White, 2001, 2003.

13. Figure inspired by Buck et al., 2018.

14. In contrast, peer supporters may also be expected to lead high responsibility work (e.g., management responsibilities like meeting with stakeholders, fundraising and writing grant proposals, or negotiating partnerships) without this being a formally negotiated aspect of their job or properly recognized, compensated, and supported as a leadership position (PeerWorks, 2022a). Again, this disregard of the peer support role takes away from the time spent providing direct support to peers.

15. See Government of Ontario, 2011, 2020; Graham & Provincial Community Mental Health Committee, 1988; Mental Health Commission of Canada, 2012; Select Committee on Mental Health and Addictions, 2010; Wilton, 2004.

16. In peer support, experiences that may cause distress and pose a worker safety concern include being asked to adopt clinical ways of operating, experiencing ethical betrayals or paternalism, and witnessing coercive practices (Victorian Mental Illness Awareness Council and Centre for Psychiatric Nursing, 2018).

17. For elaboration, see Ontario Human Rights Commission, 2008, section IV, points 1, 7, 10, and 12; Ontario Human Rights Commission, 2012, section 12; Ontario Human Rights Commission, 2016, section 6; also see Edan et al., 2021; Firmin et al., 2019; Greer et al., 2020; Leading the Change Consumer Worker Action Group, 2020; Victorian Mental Illness Awareness Council and Centre for Psychiatric Nursing, 2018; WA Peer Supporters' Network, 2018.

18. Concerningly, a recent survey of peer supporters across Canada found 85% to have completed or attended a college or university program (Rebeiro Gruhl et al., 2023), suggesting a lack of access to the discipline for those who do not hold these credentials.

19. See Government of Canada (2024) for a breakdown of hourly wages for peer supporters by province, territory, and region.

20. Peer supporters may also be viewed as uncooperative or unprofessional for speaking up or asserting their proper role (Deegan, 2004; Victorian Mental Illness Awareness Council and Centre for Psychiatric Nursing, 2018).

21. See Chaney & Copperman, 2023; CMHA Ontario, 2009; Croft et al., 2021; Gournaris, 2016; Peer Support Canada, 2022; Reif et al., 2014; Simmons et al., 2017; South et al., 2016.

22. See CMHA et al., 2005; Cyr et al., 2010; Mood Disorders Society of Canada, 2022; O'Hagan et al., 2009; OPDI, 2009, 2021; PeerWorks, 2022b; TaylorNewberry Consulting, 2014; Toronto Drug Strategy Advisory Committee, 2005.

23. For example, the Canadian Centre for Occupational Health and Safety, Employment and Social Development Canada, Ontario Human Rights Commission, and Ontario Ombudsman might collaborate with the peer support sector to investigate the psychological hazards and discrimination faced by workers in peer roles tied to their lived experience of human rights code-protected grounds (e.g., disability, race, gender identity), and give specific guidance on how the duty to accommodate and other human rights obligations apply to workers in peer/lived experience roles. Ontario Health might also mandate that peer support positions are paid a livable wage and benefits equivalent to non-peer positions and allocate funding accordingly (see CMHA, BC Division, 2023a). The Canadian Mental Health Association, BC Division (2023a, p. 63) also recommends the provincial establishment of an Independent Office of the Legislature (Office of the Mental Health Advocate) composed of people with lived and living experience who hold the authority to receive complaints, conduct systemic investigations, produce reports, and provide recommendations for reform.

24. The discipline of peer support in Canada and beyond appears to have thus far made limited use of legal frameworks to address harms contributing to or resulting from peer support drift. Exceptions include a minority of peer supporters who have begun to unionize and/or legally challenge the workplace discrimination they experience (for example, see Bedard & Perry, 2014; Goldston v. Ariel Community Care, LLC, 2022; Lefkowitz v. Administrators of the Tulane Educational Fund, 2022; Michaud et al., 2016; Ontario Public Service Employees Union — Local 425 v Brockville General Hospital, 2018; Smart, 2021).

   This limited uptake of legal mechanisms is understandable. Legal remedies for disabled people are often processed through an individualized "failure to accommodate" model rather than one of systemic discrimination and group-based harm, rendering the legal system ill-equipped to respond to the workplace inequities peer supporters face across the province (Katterl, 2022; Schoenholz, 2017; Stein & Waterstone, 2006). Participating in a legal complaint also requires time, energy, financial resources, disclosure, visibility, etc. Similarly, due to the high incidence of precarious employment (e.g., part-time and contract work), peer supporters, like other disabled people, often have reduced access to the support of a labour union (Lewis et al., 2021).

   Notwithstanding these notable limitations, it may be worth further exploring as a discipline how systems of law and legislation might be leveraged to support peer support. For example, we might learn from the class action lawsuits and organizing strategies of other communities (e.g., Hall, 2021; Thurton, 2023; Welsh, 2015), further collaborate with groups like the disability caucuses of employee unions, and advocate for amendments to human rights codes to facilitate litigation of aggregated claims of systemic discrimination (Schoenholz, 2017).

25. For example, the situation of peer support drift intersects with: mission drift and risk of co-optation in other social movements; the challenges diversity workers face in other institutions; disabled people's experiences of workplace discrimination across disability experiences and employment contexts; the overall devaluing and precarity of community care work most often performed by members of marginalized groups; the de-prioritization and disrespect of alternative (to the Western biomedical model) healing practices; and role ambiguity in other professions (see Adams, 2020; Bennett & Savani, 2011; Douglas, 2017; Jones, 2019; Lilly, 2008; Lindsay et al., 2023; Logan, 2019; Mareschal & Ciorici, 2021; Scheepers & Lakhani, 2020; Shahidi et al., 2023; Timonen & Lolich, 2019; Villanueva-Flores et al., 2017; Zagrodney et al., 2023).

26. As a place to start, see Davidow, 2023; Epstein et al., 2023; Harper, 1979, 1988; Howard-Bobiwash, 2003; Jackson, 2002; Maracle, 2018; Piepzna-Samarasinha, 2016; Sanderson & Howard-Bobiwash, 1997; Krouse & Howard, 2009; Maxwell, 2009; Reaume, 2021; Schalk, 2022; Shakur & Trinidad, 2022; Thuma, 2014; White, 2000a; Wildflower Alliance, 2024.

27. As elaborated by the CMHA, BC Division (2023a), "Since living experience of substance use is a necessary qualification for some peer positions and substance use-related disabilities are protected under the [Human Rights] Code, employers cannot prohibit all forms of drug use while at work" (p. 57).

28. See CMHA, BC Division, 2023ab; Government of Western Australia Mental Health Commission, 2022b, p. 41; Mental Health Commission South Australia, 2021.

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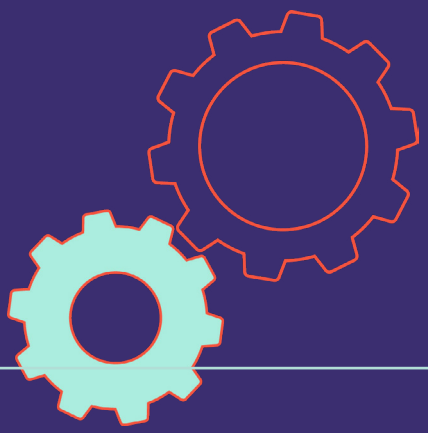

About PeerWorks

PeerWorks' mission is to strengthen and promote diverse peer voices in Ontario, through community building, information-sharing, collaboration, advocacy, and education.

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