

DEVELOPMENT OF A PEER COUNSELLOR PROGRAM

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ABSTRACT

The development of clinical peer counselling within BC Schizophrenia Society Victoria (BCSSV) would be an innovation to the local mental health community that could enhance client illness management. This qualitative action research sought to enhance alignment between lived experience of mental illness recovery and professionalism, thereby adding value to the broader field of mental health support programs. Results showed that ethics, disclosure, boundaries, human rights, definitions, readiness, training, supervision, recruitment, liability and strengths need to be further explored prior to program implementation. The conclusions suggested this type of program needs a strong ethical base, a philosophy that supports organizational readiness and change management strategies, understands the complexity of liability and utilizes already existing community resources. The recommendations support community consultation towards a viability assessment, development of an organizational wellness recovery action plan, proper program parameter development such as defining peer support vs. peer counselling, and further research into peer-led services.

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TABLE OF CONTENTS

ABSTRACT	2
ACKNOWLEDGEMENTS	3
TABLE OF CONTENTS.....	5
CHAPTER ONE: FOCUS AND FRAMING	9
Significance of the Inquiry.....	12
Cost of services	13
Benefits	13
Risks.....	14
Prevalence statistics	15
Consequences of not receiving peer counselling	15
Organizational Context.....	16
BCSSV’s current peer-led programs	16
The programs’ theoretical model.....	17
Governance structure	18
BCSSV finances and funders.....	18
BCSSV’s volunteers and staff	19
Systems Analysis of the Inquiry	19
Schizophrenia Society’s structure across British Columbia	20
Vancouver Island Health Authority	20
Schizophrenia Society of Canada	21
Canadian mental health strategy	21
Current system practice.....	22
Human rights and mental illness.....	23
Chapter Summary	23
CHAPTER TWO: LITERATURE REVIEW	25
Background of Peer Counselling in Mental Health Settings	26
Role of a peer counsellor in mental health settings	26
Theoretical foundations for the movement toward peer counselling in mental health.....	27
Value of peer counselling in mental health settings	28
Credibility of peer work.....	30
Peer Resources	32
Community need and peer services	32
Modalities of peer work in today’s healthcare climate.....	34
Best and Promising Practices in Peer Counselling	36
Standards of practices relating to counselling services, peer or otherwise.....	36
Program evaluation in peer-driven work	38
Organizational Change.....	40
Organizational change in the 21st century.....	40
Models and approaches to organizational change	42
The role of leaders in successful organizational change.....	44

The human side of organizational change and transitions, trust, and dealing with resistance.....	46
Chapter Summary	49
CHAPTER THREE: INQUIRY APPROACH AND METHDODOLOGY	51
Inquiry Approach.....	51
Participants.....	53
External experts interview participants.....	53
BCSSV’s Board of Directors.....	53
Inquiry team	56
Inquiry Methods.....	56
Data collection tools	57
Study conduct.....	60
Data analysis	65
Ethical Issues	66
Concern for welfare	67
Respect for persons	68
Justice.....	69
Chapter Summary	70
CHAPTER FOUR: FINDINGS AND DISCUSSION.....	71
Findings.....	71
Response rates.....	72
Thematic analyses.....	73
Summary of findings.....	107
Conclusions.....	109
Conclusion one: A strong ethical base is the foundation upon which any peer programming must rest.	109
Conclusion two: The philosophies behind peer counselling need to keep in mind organizational readiness and change management processes.....	110
Conclusions three: On a practical level systems need to be in place to develop a peer counselling program that consider the complexity of potential liability.	112
Conclusions four: The BCSSV is not alone in being an innovative organization and can draw upon other community resources in the mental health system if it were to develop a peer counselling program.	113
Limitations of the Research	115
Participants.....	116
Community engagement	116
Lack of research.....	117
Chapter Summary	117
CHAPTER FIVE: INQUIRY IMPLICATIONS, RECOMMENDATIONS FOR THE ORGANIZATION, RESEARCH LIMITATIONS	119
Recommendations.....	119
Recommendation one: It is recommended in the next six months that the Executive Director and board members consult with the organizational	

stakeholders, such as VIHA, peer supporters, clients in recovery from mental illness, and their families, as part of a viability assessment to determine the support for the development of a peer counselling program.	120
Recommendation two: It is recommended in the next fiscal year that the Executive Director lead the development of an organizational Wellness Recovery Action Plan (WRAP) in conjunction with the board members, staff, and volunteers as a part of strategic planning regarding peer program development.	121
Recommendation three: It is recommended in the next year that the BCSSV Executive Director and board members create clear parameters for a peer counselling role as distinct from peer support, including definition of peer counselling, a job description, qualifications statement, training needs, and a plan for recruitment.	123
Recommendation four: It is recommended over the next decade that BCSSV Executive Director and board members engage in further research and leadership on standards of practice for programs involving peers at a higher level of service.	125
Organizational Implications.	127
Internal implication regarding fear of change.	127
Visionary implications for the mental health system.	129
External implications involving community.	129
Organizational response.	130
Implications for Future Inquiry.	131
Chapter Summary.	132
CHAPTER SIX: META-REFLECTION ON INQUIRY.	134
Action Research Process.	134
Quality of participation.	135
Personal Learning about the Issue.	137
Contribution to the Knowledge.	137
Self.	138
Broader social context.	138
Chapter Summary.	139
REFERENCES.	140
APPENDIX A: EXPERTS LETTER OF INVITATION (INTERVIEW).	146
APPENDIX B: BOARD LETTER OF INVITATION (INTERVIEW).	148
APPENDIX C: LETTER OF INVITATION (FOCUS GROUP).	150
APPENDIX D: EXPERTS INFORMED CONSENT (INTERVIEW).	153
APPENDIX E: BOARD INFORMED CONSENT (INTERVIEW).	155
APPENDIX F: INFORMED CONSENT (FOCUS GROUP).	157
APPENDIX G: INQUIRY TEAM MEMBER LETTER OF AGREEMENT.	159
APPENDIX H: EXPERTS PROTOCOL & QUESTIONS (INTERVIEW).	161
APPENDIX I: BOARD PROTOCOL & QUESTIONS (INTERVIEW).	163
APPENDIX J: PROTOCOL & QUESTIONS (FOCUS GROUP).	165

APPENDIX K: TRANSCRIPTIONIST CONFIDENTIALITY AGREEMENT 168

CHAPTER ONE: FOCUS AND FRAMING

There has been a strong recommendation for people in recovery from mental illness to be employed in multi-level positions within the health care system. The Mental Health Commission of Canada (2012) stated, “People living with mental health problems and illnesses and their family members are ‘experts by experience’” (p. 31). There has been value in experiential knowledge of health systems. The work of people in recovery from mental illness has become a necessary component to client care. As noted by the Mental Health Commission of Canada (MHCC),

The mental health workforce must also do more to welcome people with lived experience into positions at all levels . . . to enhance the quality of the services provided and to contribute to the on-going transformation of the mental health system. (p. 31)

It has been important that people in recovery from mental illness take on leadership roles, locally and nationally. “Many countries report that the participation of people living with mental health problems and illnesses and their families is a critical element in transforming health systems” (Mental Health Commission of Canada, 2012, p. 84). New peer-led initiatives were being encouraged that support the recovery of individuals seeking care.

The BC Schizophrenia Society Victoria (BCSSV) had an opportunity to research the development of a clinical peer counselling program that was in alignment with the National Mental Health Strategy recommendations (Mental Health Commission of Canada, 2012). At the time of this research within the mental health system, the development of best practices for peer support was a strong focus. “The development of guidelines and standards of practice for peer support will enhance the credibility of peer support as an essential component of a transformed mental health system and encourage its use” (p. 51). Peer programs are value added for

organizations. For example, “Peer Support works because people who have experience with mental health problems and illnesses can offer support, encouragement, and hope to each other when facing similar situations” (p. 51). At the time of this research, the BC Schizophrenia Society Victoria operated a Peer Support Program with 14 workers who were in recovery themselves from a diverse range of illnesses. They utilized their insights to support client recovery and goal setting. “We have used a broad definition of peer support for this project and define it as any organised support provided by and for people with mental health problems” (O’Hagan, Cyr, McKee, & Priest, 2010, p. 42). In contrast, a peer-counselor program would involve a peer with professional status and a clinical education. Shreve (1991) stated that at the Westside Center for Independent Living, “Staff define peer counselling as ‘counselors with disabilities who have professional, academic, clinical training providing family, group, couples, and individual counselling’” (p. 6). The focus of this research was to explore the scope of clinical practice counselling run by a person with mental illness in a role where the mental illness would be disclosed to help the client.

To align a BCSSV peer-led counselling program with a clinical background, it was important to understand why incorporating a peer perspective into a clinical role was necessary. For example, and in contrast, a non-peer clinical counselor’s training program may consist of lessons in brief or long-term counselling, crisis interventions skills, facilitation and mediation, psycho-educational programming, consulting, and clinical supervision or instruction (BC Association of Clinical Counsellors, n.d., para. 8). Alternately, peer support typically has not involved counselling the client. The BC Schizophrenia Society Victoria needed to research the

difference between clinical work, peer work, and the combination of the two in developing a peer counselling program.

Peer counselling could meet the needs of clients with mental illness in a new way. The scope of issues addressed in peer counselling may include grief and empowerment, self-identity and life meaning, suicidal ideation, power and control issues, relationships (with family/friends, doctors, employers and instructors), and social protection and human rights. These counselling issues, partnered with the empathy a peer could bring to the counselling process, would add a level of resonance to the relationship, which is often unmet in psychiatry or counselling practice. Rummel-Kluge, Stiegler-Kotzor, Hansen, and Kissling (2008) stated, “We believe that the concept of inpatient peer counselling meets an as yet unattended need in psychiatry in general and in schizophrenia in particular” (p. 361). Peer support bridged gaps, yet there may have been some unmet client needs in this program as well. As noted by O’Hagan et al. (2010):

Some peers working in mainstream settings describe feeling dominated by professionals who do not understand the value of their work. Ongoing system change and training for professionals to develop the skills to work with and deliver recovery-oriented, anti-oppressive services in partnership with peer providers is required. (p. 10)

As the principal researcher in this inquiry project and one of four core staff within BC Schizophrenia Society Victoria in my role of Administrative Coordinator, I attempted through this research to answer the following question: How can the BC Schizophrenia Society Victoria develop a credible and viable peer counselling program? Sub questions included:

1. What resources are currently available for peer counselling and what gaps in resource requirements exist that would need to be addressed?

2. What client needs could a peer-counselor address, which are not met in the current peer support program?
3. What benefits exist to the development of a peer counselling program?
4. What risks could BCSSV face in introducing peer counselling and how can these be mitigated?
5. What implications do these findings have for the broader application of peer counselling by other non-profit community organizations whose purpose is to support those with mental illness?

Significance of the Inquiry

Although the credibility of peer work is advancing, stigma and discrimination still exists. The MHCC (2009) Opening Minds initiative put forth efforts to reduce stigma and discrimination within a 10-year period. This program aims to evaluate programs successful at reducing stigma and replicate them across Canada (MHCC, 2012, p. 33). The development of a peer counselor program as a peer leadership opportunity could support stigma reduction in healthcare. “Strong leaders with lived experience and their families working with strong organizations will not only contribute to the transformation of service delivery, planning and administration, but their involvement will also help to end stigma and discrimination” (p. 92). Through an online gap analysis, I determined there to be no services in Victoria, BC, that offered clinical peer counselling to mental health clients. However, there were peer services at the Seniors Serving Seniors Centre and the University of Victoria. Topics discussed in the next section include cost of services, benefits, risks, prevalence statistics, and consequences of not receiving peer counselling.

Cost of services

Professional psychologists are regulated to charge \$100 per 50 minute session and do not qualify for government subsidies (BC Association of Clinical Counsellors, 2008, para. 1). The services of psychologists and counselors are not covered by MSP (Government of British Columbia, Ministry of Health [BC Ministry of Health], 2013, para. 3). The BC Schizophrenia Society Victoria's (BCSSV) peer support and other programs are offered free of charge. A peer counselling service that is focused on clinical practice could be made as accessible. Budden (n.d.) has suggested:

Lack of services has left many people living with schizophrenia inappropriately placed in jails and prisons. Medication, psychosocial rehabilitation, community-based supports and recovery-oriented mental health services can help people living with schizophrenia and psychosis lead meaningful and satisfying lives. (para. 3)

Other areas across Canada, such as the Government of Nova Scotia, Mental Health Services (2013) have supported:

Providing appropriate, accessible services to adults with serious and persistent mental illness is important. The province of Nova Scotia is committed to a comprehensive, integrated, evidence-based system of mental health services focusing on health promotion, prevention, treatment, recovery, and support for individuals and families. (para. 2)

Benefits

On a global level, the potential benefits to developing a peer counselor program include advancing the importance of peer employment initiatives and making a contribution to peer program research, evaluation, and training, which are areas yet to be explored. As Burns and Salzer (2001) explained, "Consumers are filling the employment roles in a variety of positions including case managers . . . on Assertive Community Treatment Teams, vocational and

employment coaches” (p. 513). This showed the current reality of advancing peer involvement in the healthcare of clients with mental illness. Other benefits to peer counselling include role modeling for the client, the possibility to develop coping skills, being able to relate to the counselor, and being able to build self-worth (Sisco, 1992, Advantages section, para. 5).

Not only is client empathy and skill building important to counselling work, it benefits the community in changing the way the public thinks about mental illness. “The community, of course, is helped to form a positive image of the disabled. More important, the service to persons with disabilities is improved allowing these persons to take up a more meaningful role in the community” (Sisco, 1992, Advantages section, para. 5).

Risks

There are some risks associated with hiring a person in recovery to run a peer counselling program. Carter (2000) stated, “Disability may involve physical, sensory, or mental losses; or environmental, economic, and social/attitudinal barriers. These conditions can lead to serious psychological stress” (para. 7). This is a general description of what people with mental illness experience. Even a trained clinical peer counselor may sometimes experience these types of symptoms. Proper supervision needs to be in place to monitor any staff member in a professional role who experiences mental illness. It is important to engage in an ongoing evaluation process. Carter further suggested that ongoing and scheduled staff meetings with the peer counselor can help with monitoring client progress and minimize the amount of risk involved in this type of program (para. 14).

Prevalence statistics

Mental health statistics are valuable for the development of programs and services to serve clients managing mental illness. According to the Centre for Addiction and Mental Health (n.d.), some mental illness statistics for Canada included that “1 in 5 Canadians will experience a mental illness in their lifetime. The remaining 4 will have a friend, family member or colleague who will” (para. 1). They further stated, “Only one-third of those who need mental health services in Canada actually receive them” (Access section, para. 1). Mental illness may cause an inability to work in as many as 500,000 in Canada (Cost to Society section, para. 2). These statistics show the magnitude of people struggling to manage their symptoms and have the potential to access different services to alleviate suffering.

Consequences of not receiving peer counselling

Being diagnosed with a mental illness can be the beginning of the journey back to our authentic selves. According to Six (1993),

To examine our belief structures and to constantly strive to be what is in us to be is to move towards authenticity. To refuse to do so, to live in denial of our freedom of choice and our radical responsibility. (p. 2)

Six further stated, “The more consciously aware and critically evaluative we are of our attitudes, feelings, words, thoughts, beliefs and behaviors, the more creative potential we possess—the more authentic we become. Peer counselling is one doorway to authenticity” (p. 2).

Being a peer counselor means that there is a degree of resonance for the client by working with someone who has been there. This resonance is a deep sense of authenticity and connection: a knowing of what the client has been through. Without access to peer counselling, a client’s social development or cognitive ability may be delayed. As was also explained by Six

(1993), “Peer relationships are crucial in social development. It is well documented that peer relationships contribute significantly to social and cognitive development and socialization particularly in childhood and adolescence” (p. 19).

Organizational Context

The mission statement of the BCSSV (n.d.b) is: “To improve the quality of life for those affected by schizophrenia and psychosis through education, support programs, public policy, and research” (para. 1). BCSSV is a recovery-based organization. It provides support for those with a variety of mental health concerns with or without addictions. The BCSSV also serves family, friends, and supporters of people with mental illness. Two-thirds of the people supported by the BCSSV have schizophrenia or psychosis, and one-third have a mood disorder (BCSSV, n.d.a, para. 1). BCSSV supports clients by providing access to information, resources, and strategies that are intended to assist clients to manage their lives (para. 1). In this section, I discuss BCSSV’s current peer-led programs, the programs’ theoretical model, governance structure, BCSSV finances and funders, and BCSSV’s volunteers and staff.

BCSSV’s current peer-led programs

At the time this research was conducted, the BCSSV ran four peer-led programs. These included the Peer Support Program, the Wellness Recovery Action Plan (WRAP), the New Light Recovery Workshop (NLRW), and the Recovery & Hope Support Group. The NLRW and the WRAP ran in the spring and the fall. The BCSSV took registration throughout the year for both seasons. At one time, the NLRW had a waitlist of approximately 15 people for the next program. The WRAP was new to the BCSSV and had a six-person waitlist for the next program, which was slowly building awareness as the program grew. The Peer Support Program served 54 new

clients in the fiscal year of the time this research was undertaken. The Recovery & Hope Support Group had 23 meetings with 28 clients, some with repeat attendance (BCSSV, 2012, p. 8).

The programs' theoretical model

The theoretical model that supported the basis for these programs was the bio-psycho-social-spiritual-recovery-based empowerment model brought forward by the executive director of the Canadian Schizophrenia Society (Summerville, 2007, p. 4). These programs also used a client-centred approach. The BCSSV executive director oversaw the facilitation, staffing, and vision that kept these programs in operation.

The BCSSV upholds the vision of the recovery movement as the very core of what our organization is striving for. The work of professionals and leaders in the recovery movement who are people with mental illness, yet with a high degree of accomplishment despite the limitations of illness, inspired our work with clients and their families. Deegan (1996) stated, "Those of us with psychiatric disabilities can become experts in our own self-care, can regain control over our lives, and can be responsible for our own individual journey of recovery" (para. 10). The BCSSV operates in this manner. We build the capacity of our workers in recovery. We support our staff members who are in recovery to develop or run programs, while utilizing their insights to help others in need. The organization builds upon these principles to enhance practice and transform their programs into innovations. In this regard, the BCSSV aligns its culture to reflect the mental health strategy devised by the MHCC. As noted by Senge (2006), "If any one idea about leadership has inspired organizations . . . it's the capacity to hold a shared picture of the future we seek to create" (p. 9).

Governance structure

BCSSV is a non-profit society under British Columbia's Society Act (1996). As a requirement of this Act, our charity is governed by an elected board of directors. The BCSSV Board members are of diverse backgrounds. This diversity includes people living with mental illness, family members of those living with mental illness, and professionals in the community. BCSSV Board members operate the BCSSV from a "traditional" model (Macnamara & Banff Executive Leadership, 2010, p. 1). Macnamara and Banff Executive Leadership (2010) further explained that "a basis of this model is that the structure of the Board itself, and the way in which it makes decisions, holds meetings, and the parameters by which it must abide are put into an approved structure and format" (p. 1). Although the board structure is defined and set with policy and parameters around activity, at the time this research was conducted the BCSSV Executive and Board had been in a transformative phase of becoming more of a Committee/Working Board. This meant all board members were starting to contribute to the execution of fundraising efforts, event coordination, and operational duties. This was due to the BCSSV being a largely volunteer-run organization with ever-increasing demands on the four core staff members who needed the knowledge and expertise of the Board.

BCSSV finances and funders

The BCSSV fiscal year runs from April 1 to March 31. We are required to evaluate all our programs and provide statistical reports to our funders. One of our main funders is the Vancouver Island Health Authority (VIHA), which funds our core programs and operational costs, including salaries of the core staff. Other funders include the Vanderkerkove Foundation, Victoria Foundation, private donors, membership, event sponsorship by local businesses, and

anonymous event donors. In 2011, our overall revenue was \$259,807, and in 2012 it was \$331,043 (BCSSV, 2012, p. 11).

At the time this research took place, the BCSSV peer support program was funded by the United Way and was in the second year of a three-year process of funding. The focus of this program in the coming years was to expand, improve, and support our trained workers to facilitate the WRAP program. The peer workers developed their own personal and work WRAPs. They also engaged in the development of a group WRAP for their debriefing meetings as a team. This was all with the support of the United Way funding and parameters set within the funding proposal.

BCSSV's volunteers and staff

The BCSSV has a total of 12 in-office volunteers who undertake frontline work for the organization, which includes fielding phone calls, supporting clients, explaining our programs, making referrals, and regular office tasks like folding pamphlets. The BCSSV hosted five annual events throughout the year: Christmas Dinner and Dance, Bungy Jump, Iris Luncheon, Jazz event, and the Picnic in the Park. Each event has a range of volunteers from 15 to 60 depending on the event needs. We have four core staff: the executive director, the administrative coordinator (the role I personally filled), the accountant, and the family counsellor.

Systems Analysis of the Inquiry

In this section, the focus is on the external mental health system surrounding the BCSSV. It describes the national, provincial, and local climate of mental health activities. This includes organizations, committees, and established best practices in peer work.

Schizophrenia Society's structure across British Columbia

“The British Columbia Schizophrenia Society was founded in 1982, as a provincial organization. Across the province, there are 30 branches that exceed 1,600 members” (BCSSV, n.d.a, Organizational Structure section, para. 2). British Columbia Schizophrenia Society Provincial Office (2013) has explained that “BCSS has grown into a province-wide family support system with 30 Branches, 11 Regional Coordinators, 3 Program Coordinators, and over 1,600 members” (para. 1).

Vancouver Island Health Authority

The Vancouver Island Health Authority (VIHA) is the regional health authority who, under the auspices of the BC Ministry of Health, is responsible for the delivery of health services on Vancouver Island, the Gulf Islands, and some parts of the Sunshine Coast, and as such, Greater Victoria falls within its operational areas. The Mental Health and Addictions Services of VIHA has explained its services as follows: “Acute psychiatric hospitalization provides multi-disciplinary assessment and treatment services to stabilize acute symptoms in a safe environment. After stabilization, inpatient services link the patient to community mental health and addiction services for follow-up and continued treatment and recovery” (VIHA, n.d., Acute Inpatient Care section, para. 1). BCSSV is one of these community mental health services to which VIHA refers its clients. VIHA has also stated,

Our priority is providing appropriate accessible services for adults with serious mental illness and/or addictions. We provide services in the context of a wider support network including other government agencies, aboriginal health organizations, community partners, public agencies, friends and families. (para. 1)

Schizophrenia Society of Canada

As a national organization, the Schizophrenia Society of Canada (SSC) has been in operation since 1979 (Schizophrenia Society of Canada, n.d., para. 2). The SSC is dedicated to awareness building through public education, stigma reduction, family support, and mental health policy change on a legislative level (para. 4-7). The work the SSC has done supports the credibility that peer-led services “provide supports that go way beyond standard healthcare” (Schizophrenia Society of Canada, 2007, p. 23).

Canadian mental health strategy

With the help of organizations and individuals across Canada, MHCC has developed a mental health strategy. This project was driven by the fact that Canada was the only G8 country without a mental health strategy and suggested that Canadian organizations might need to adjust to current trends in the development of mental health care. MHCC (2012) has stated,

This *Strategy* recognizes that we will never be able to adequately reduce the impact of mental health problems and illnesses through treatment alone. As a country, we must pay greater attention to the promotion of mental health for the entire population and to the prevention of mental illness wherever possible. Compelling evidence for the effectiveness of promotion and prevention programs has been accumulating in Canada and internationally for many years, and we cannot afford to wait any longer to implement these programs as widely as possible. (p. 9)

Research on creating a peer counselor role may help support the advancement of peer work. This is where Canada is heading as suggested by MHCC. MHCC (n.d.) has a current project called the “Consumer/Peer Research Development (CPRND) Project”, and the project objectives include “to enhance the capacity of consumer/peer researchers across Canada” (p. 1).

Current system practice

How the BCSSV structures a peer counselling program would be informed not only by this inquiry, but also by what policies, best practices, and procedures are available nationally, provincially, and locally. At the time of this research, professional social work in BC was guided by standards of practice. The social worker maintains professional boundaries, avoids conflict of interest, and keeps the client's information confidential (BC College of Social Workers, 2009, p. 12). These standards include that "social workers do not engage in the practice of social work . . . while suffering from illness or dysfunction which the social worker knows or ought reasonably to know impairs the social worker's ability to practice" (p. 12). As the health of the social worker is important to the professional's work with the client, these standards were set to protect the client's well-being. Similarly, in professional counselling practice, the counselor is to "limit self-disclosure in counselling clients only to that which serves the client's best interests" (BC Association of Clinical Counsellors, 2009, p. 7).

There is growing support from mental health authorities such as VIHA to incorporate people in recovery as employees in mental health work. In regards to the Assertive Community Treatment Teams that employed peer workers, "The peer support specialist must be paid a salary commensurate with other staff members. In addition, consumers who have the credentials can be employed in any other required positions and should be paid at the professional rate" (BC Ministry of Health, 2008, p. 22). This progress toward employing people with lived experience of mental illness shows recognition of the value of their insight to help clients.

Human rights and mental illness

Human rights issues in regards to mental illness need to be addressed. In this regard, the social determinants of health “are a group of social factors or ‘living conditions’ that influence the overall health of individuals” (United Way of Greater Victoria, 2011, p. 32). This includes “income distribution, education, job security, employment and working conditions, early childhood development, food security, housing, social safety network, health services” (p. 32). This relates to human rights issues in regards to access to proper and diverse ranges of care leading to “prevention and social inclusion” (p. 32). Martin (2009) articulated that the “Disability Inclusion Model . . . includes adopting a human rights perspective, and addressing the structural barriers and systemic issues that deny people access to the same level of services and resources as those with other health concerns” (p. 15). A way to break down the barriers of stigma is to utilize self-disclosure techniques with someone who has been there. Martin explained that “disclosure is found to have positive health and social benefits and helps people to reframe the negative experience of illness more positively” (p. 22).

Chapter Summary

The background of the Schizophrenia Society, the recovery movement, and inclusion of peers in mental health work have been explored in this chapter. The description of the structure of the organization, its provincial affiliates, and national parent agency offered a view of the connection between our stakeholders. Overall, peer services need policy and practice to support the work they aim to achieve. Keeping human rights in the forefront of the recovery movement will allow system change to occur that allows for the employment of people with mental illness

in professional fields. A review of the literature that aligns with the research topic is provided in the next chapter.

CHAPTER TWO: LITERATURE REVIEW

In this review of literature, I first aimed at exploring various aspects of peer counselling. The goal was to provide a theoretical background, which would inform the inquiry question: How can the BC Schizophrenia Society Victoria develop a credible and viable peer-counselling program? Through devising a clear role description of peer counselling as opposed to peer support, the organization could begin to differentiate the program activities. Information was a key component to creating the basic structure for peer counselling. Wheatley (2006) suggested, “Instead of a limiting thought that ‘information’ is power, they began to think of information as ‘nourishment’” (p. 101). To nourish our organization was to provide information on peer counselling programs that could be successfully implemented within our organization. The topics that will be covered in the literature review include: (a) background of peer counselling in mental health setting, (b) peer resources, (c) best and promising practices in peer counselling, and (d) organizational change.

Secondly, the importance of understanding the dynamics of organizational change and creating a change management plan in the development of a peer counselling program was vital and was also covered in the literature review. To implement such an innovative program, the BCSSV would need to develop a structure based on change management processes to proceed successfully. Wheatley and Kellner-Rogers (1998) stated, “First, when thinking about strategies for organizational change, we need to remember: Participation is not a choice. We have no choice but to invite people into the process of rethinking, redesigning, restructuring the organization” (para. 22).

Background of Peer Counselling in Mental Health Settings

By understanding what peer counselling is and what it does when compared and contrasted with other forms of peer supports in the field of mental health, it is possible to establish clear guidelines for how the work could be implemented, how peers need to be trained, and how to control program dynamics. Information is provided on the various roles of peer counselling, the value to the client, and its credibility.

Role of a peer counsellor in mental health settings

According to Crews (2008), “The peer counselor is a resource for short term and basic counselling at a peer level, and in this capacity he works in cooperation and in consultation with . . . other helping resources” (p. 2). Crews also claimed a peer counselor “should have a commitment to help others and the ability to interact with individuals from a wide range of backgrounds and situations” (p. 11). Furthermore, Rummel-Kluge, Stiegler-Kotzor Hansen and Kissling (2008) stated, “The ‘peer to peer’ approach—getting help from someone who is or was in the same situation—is very common in different situations in life” (p. 1). What Rummel-Kluge et al. stated supported comments made by Scott (2011), who commented that “peer support is grounded in two way relationships, where “helping can take place on both sides” (p. 176). Regarding the skills of a peer counsellor, Scott also stated, “While authentic and immediate experiences of empathy do sometimes arise, the development of relationships in which empathy can be created repeatedly requires skilled work” (p. 179). Overall, the authors reviewed agreed that one-to-one peer counselling is supported as a way for clients to connect with someone who has been through similar mental health issues.

Although various definitions of peer counselling have been provided, Simoni, Franks, Lehavot, and Yard (2011) acknowledged that “most reports on peers do not define terms or link interventions to specific peer responsibilities” (p. 352). However, Simoni et al. (2011) explained, “Peers engage in a wide range of health promotions and disease prevention activities, many of which are similar to the services of a professional . . . would typically provide” (p. 353). “Theoretically, these programs are planned, administered, and staffed by people with severe mental illness for people with severe mental illness” (Fuller, 2009, p. 1). Although lay people who are in recovery run peer counselling, the research pointed out that it can support the work clinicians do to help their clients. The role of a peer counsellor, according to Crews (2008), includes “crisis intervention, potential conflicts of interest and how to handle them, scope of practice, assessment for referrals” (p. 3). In addition, “several studies highlighted peers’ function [in] providing social, emotional, and instrumental support for health-related behaviour change (Simoni et al., 2011, p. 352).

Theoretical foundations for the movement toward peer counselling in mental health

From a theoretical standpoint, it has been found that “the people who participate and help others are fostering their own empowerment, which ideally will lead to a higher quality of life” (Fuller, 2009, p. 6). The research explained the process of empowerment that occurs for the counsellor and the client.

Within these programs, consumers need to be trained and employed not only on how to perform their job duties, but also on how to recover from mental illness. Once they understand their own journey through the process of recovery, they can then share their experience, strength, and hope with other individuals who wish to recover from their illness. As well, they can share their understanding that the recovery process is unique for each person, and he or she can determine their own definition of recovery. (Fuller, 2009, pp. 21-22)

Fuller (2009) also stated, “Essentially, it is people with mental illness sharing experiences, strength, and hope with others who are experiencing the same obstacles in their lives and working towards a common goal of recovery from mental illness” (p. 2). The recovery process involves a level of hope achieved by knowing the self and managing illness.

Accordingly, Rummel-Kluge et al. (2008) suggested that “‘peer-counselling’ is a method for providing information, advice, and emotional support about an illness or a medical condition by persons who were or still are affected themselves” (p. 357). Scott (2011) supported this and explained, “This approach to peer support emphasizes empowered choice and the importance of peer relationship; it uses tools such as strengths profiles and goal plans to assist peers through a peer mentoring approach” (p. 174). Overall, Simoni et al. (2011) concurred with Fuller, Rummel-Kluge et al., and Scott that in peer work, “the helping relationships they develop differ from those in naturally occurring networks, most notably in their reach, scope, and the lack of anticipated reciprocity” (p. 353). Finally, according to the Simoni et al., peer counselling is a method of care based on recovery, mutuality, and empathy.

Value of peer counselling in mental health settings

There has been much value recognized in peer-driven interventions. According to Simoni et al. (2011), “Support from similarly situated others may foster self-development, decision making skills, and a sense of community” (p. 356). Based on his study on mutuality and authentic support, Scott (2011) stated, “Peer supporters encouraged their peers to talk about the experiences themselves, and thus normalize experiences of extreme mental distress” (p. 174). A peer counsellor “having taken medication for years, can function as a positive role model”

(Rummel-Kluge et al., 2008, p. 360). Furthermore, Rummel-Kluge et al. (2008) went on to state that information and the sharing of experiences with a peer counsellor can lead clients to empowerment (p. 360). Similarly, regarding peer work, Scott (2012) wrote, “Thus, peer support involves, to differing degrees, a focus of reciprocity, transformative relationships, mutuality, and empowerment” (p. 175).

“Essentially, this kind of help can boost self-esteem of the consumers which in turn can suppress self-stigma associated with mental illness and promote recovery from severe mental illness” (Fuller, 2009, p. 6). Fuller (2009) further explained the results of a study: “Program participants had fewer crisis event and hospitalizations, improved social functioning, greater reduction in substance use, and improvements to quality of life” (p. 23). Rummel-Kluge et al. (2008) stated, “During the counselling, it was possible to address all problems and questions related to the illness in the broadest sense” (p. 360).

Peer counselling can be built on compassion and empathy. The process of speaking with a peer can build a sense of acceptance. It can also build self-esteem and hope for the future (Fuller, 2012, p. 29). “The levelling of power differentials that can occur in peer interventions may keep recipients engaged in the intervention, particularly recipients from marginalized groups who may be reluctant to seek help because of prior experiences . . . of discriminations” (Simoni et al., 2011, p. 356). There has been much value to peer support according to Simoni et al. (2011), who observed,

common rationales include that peers are less expensive and more readily available than professionals and thus peer interventions must be more sustainable, or that working as a peer can be an enriching opportunity for peers themselves, leading to personal growth and employment opportunities. (p. 354)

In regards to the value of peer counsellors in the military, Crews (2008) explained, “We are about making better leaders, better human beings . . . whether on the battlefield of conflict or on the battlefield of life” (p. 4). Another value to working with a peer counsellor is that “the helper receives social approval from the person they help and others. The stigma associated with mental illness and seeking mental health services does not exist within consumer operated services” (Fuller, 2012, p. 29).

Finally, according to Rummel-Kluge et al. (2008), some topics that would be of value for the client to address include symptoms, addiction, relapse prevention, medication, and side effects. In this relationship, “Peers can provide realistic opportunities for individuals to practice skills and thus gain mastery” (Simoni et al., 2011, p. 356). This includes self-efficacy developed from vicarious learning, observation, and the social persuasion of the counsellor (p. 356). Furthermore, as Scott (2011) pointed out, “This is directed at clearing the obstacles to the development of genuinely caring relationships and then stepping back from active intervention” (p. 179).

Credibility of peer work

Peer programs need credibility to deliver proper care in the mental health system. “Currently, peer interventions are used in diverse settings throughout the world and across different age groups to target a broad range of physical health outcomes” (Franks, Lehavot, Simoni & Yard, 2011, p. 351). Policies have been developed to support peer workers as non-professionals in a variety of settings in health care (p. 351). This shows that credibility has been built in some settings. According to Rummel-Kluge, Stiegler-Kotzor, Schwarz, Hansen & Kissling (2008), “As clinical experience suggests, the credibility of a peer can be higher than that

of a professional team member, especially when it comes to medication” (p. 360). This is due to the understanding a peer has of personal medication use and the role modeling they do (p. 360).

Credibility in peer work was built upon the type of relationship a peer has with their client. However, friendship issues can blur the lines between ethical boundaries and the needs within the peer relationship between a paid worker and an unpaid client (Scott, 2011, p. 180). These boundary issues could be managed with organizational protocols, and professional boundaries can be established (p. 180). The lived knowledge of systems is a credible source of peer insight into mental health systems: “Essentially, it is people with mental illness sharing their experience, strength, and hope with others who are experiencing the same obstacles in their lives and working toward a common goal of recovery from severe mental illness” (Fuller, 2009, p. 2). This relationship can be one of resonance and understanding of what the client is experiencing that is as valuable as professional care.

Peer services work to support client empowerment. Fuller (2009) stated, “Essentially, this kind of service can boost self-esteem of the consumers which in turn can suppress self-stigma associated with mental illness and promote recovery from severe mental illness” (p. 6). It can also increase the quality of life of peer workers who provide care to clients (p. 6). Participants of services run by peers that were carefully planned and developed were shown to believe these services were helpful for recovery and empowerment (p. 53).

Credibility comes from the preventative results that peer work can offer. Rummel-Kluge et al. (2008) explained, “Peer counseling appears to be a potentially useful strategy in the treatments of patients with schizophrenia, providing additional information on relapse prevention and advice and encouragement from peer to peer” (p. 361). The sharing of the knowledge that

peers have of managing their illness can be seen as a credible means to support recovery in others and lead to prevention of relapse. The knowledge peers have of recovery processes and illness management can also influence client progress and outcomes. Franks, Lehavot, Simoni & Yard (2011) added to this discussion in stating, “If research can show that peers improve behavioural outcomes without affecting belief or motivation mediators, the science of behaviour change itself would be positioned to benefit from exploration of the mechanisms of peer influence” (p. 354). Resources are an important part of this process.

Peer Resources

Through building knowledge of community needs for peer work and types of peer practices, it is possible to understand peer care. Current types of peer work and innovations in peer-led service and care are discussed in this section. Peer services that existed at the time of this research are described through the lens of researchers, professionals, and people in recovery from mental illness, including what makes them successful.

Community need and peer services

At the time of this research, practiced peer programs and development of new innovative models of peer care supported reduction in the cost to the system of taking care of people with mental health issues.

The problem that plagues this traditional system is that funding from both federal and state governments for mental health services is dwindling, and the system can no longer effectively serve all of the population of consumers with mental health disabilities. Therefore, a more cost-effective system needs to be established (Fuller, 2009, p. 1).

Peer services are a less costly means to provide care (Fuller, 2009, p. 2). Furthermore, “Consumer leadership should be encouraged to define issues, design programs, undertake

research, and evaluate program success” (Martin, 2009, p. 8). The knowledge and understanding of peers can support client recovery, and recovery in turn reduces the financial impact clients have on the system (Fuller, 2009, p. 2). According to the O’Hagen, Cyr, McKee and Priest (2010), “A well-rounded and increasing amount of research evidence connects peer support to reduced hospital stays, lessened symptoms, better social support and increased quality of life” (p. 8), which could save tax payers millions of dollars (p. 8).

Including peers in the workforce has value. As posited by Martin (2009), “A successful social inclusion program challenges every citizen to re-think their assumptions and take steps to create an inclusive social quilt where rights are respected, differences are valued, and we all belong” (p. 6). Martin went on to say that a social inclusion model “acknowledges the importance of employment and economic inclusion” (p. 7). A clinical peer counsellor role is in alignment with social inclusion ideals and meets community needs. Inclusion models create a healthier vision for the mental health of our communities.

Furthermore, our communities need more research to support the inclusion of peer-directed services in the healthcare system: “Peers are increasingly recognized as potentially powerful agents in promoting health and well-being. Future research and implementation of work in this area, if carefully conducted, can contribute to their success” (Franks, Lehavot, Simoni & Yard, 2011, p. 357). Research on peer-directed care can support its success and enhance current system practice. This could improve systems for client care and meet the needs of those in recovery from mental illness as well as their families on a more inclusive level.

Modalities of peer work in today's healthcare climate

Peer-led supports have been operating throughout history. According to Franks, Levahot, Simoni and Yard ((2011), “The first tradition predates biomedicine and includes lay healing care based on practical as well as spiritual understandings of health and illness. . . . The second tradition, peer education, is a longstanding practice that has been adopted in contemporary settings” (p. 351). Over the years, peer work has adapted and transformed. “Contemporary peer interventions derive from diverse conceptual and theoretical foundations that both guide and limit peer work” (p. 352). Although limitations exist, in modern times, there were numerous forms of peer-led services that operate across the world.

For example, in the year 2001, a Peer Leader model was developed to meet the needs of a care facility (Appleby, 2008, p. 4). This initiative supported the idea that peer skill, knowledge, and problem-solving abilities could promote sustainable safety and prevention strategies. This peer model, although not a mental health model, showed the type of peer work that is being incorporated into our health systems. Another health model, the Assertive Community Treatment Team (ACT), utilized peer specialists as integrated members of the treatment team (BC Ministry of Health, 2008, p. 14). ACT approach reflects “a client-centered, recovery-oriented mental health service delivery model . . . for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most serious mental illnesses” (p. 7). Peer support specialists offer individual services that support client self-determination and their ability to make decisions (p. 22). Peer specialists act as consultants to professional team members, and their opinions, thoughts, and ideas are respected (p. 22).

According to the MHCC (2010), peers played a role in supportive housing, employment and education, emergency departments, mentoring, counselling, peer-driven business models, and advocacy (p. 49). The adoption of peer work in these areas showed multiple modalities of care within which peers can provide service. Within these areas of health care, there are specializations such as “peer support initiatives for people with a diagnosis or mental illness specialize in the population they serve” (p. 49). These included culture, language, gender, life stage, and sexual orientation (p. 49). This showed there is a diverse range of opportunity for peer work.

Methods of peer-to-peer care could be linked to support groups, mentorship, community health work, and peer education (Bartone et al., 2011, p. 6). Psychiatric care programs developed by people in recovery from mental illness “promote the helper principle” (Fuller, 2009, p. 5). This principle of using insights to support clients is the basis for any peer work in mental health systems. All the modalities discussed in this section shared a common thread—that peers, people who understand the clients’ experience, can and do make a difference in today’s healthcare climate and in the lives of those involved.

Another modality developed around a peer framework is co-counselling. This is where two peers take turns counselling each other in a session. “Co-Counselling is peer because all co-counsellors have the same status. There are no ‘experts’ or ‘therapists’ helping you sort out your issues” (Talbot & Wilson, 2012, p. 20). This type of peer care is a mutual exchange based on peer skill and knowledge. Overall, the varying peer modalities are diverse and contribute to the development of the peer movement in health care.

In summary, the mental health community needs peer services to complement existing professional mental health care. There is room to utilize existing peer programs or innovate by implementing a peer counselling program within mental health settings. As a community, we could draw upon the structures, policies, and processes of existing peer programs to further advance the peer movement. The best and promising practices and evaluation of peer counselling services are explored next.

Best and Promising Practices in Peer Counselling

Through researching best and promising practices, the BCSSV can understand what was needed for peer counselling to be established. Guidelines on how to conduct the work of peer counselling could create parameters that promote ethical practice. Policy and legislation could support peer work. Peer program evaluation could ensure ongoing improvement and transformation of the work being done by peers.

Standards of practices relating to counselling services, peer or otherwise

The counselling field has an ongoing process to support the establishment of best practices. “Many of the standards of practice are generic in nature and do not anticipate every practice situation or address all of the ethical challenges with which counsellors are confronted” (Canadian Counselling and Psychotherapy Association, 2008, section Standards of Practice, para. 8). Although not deemed professional counsellors, peer workers in mental health need to have best practices to guide their work. With the development of peer services, best practices have stated that peer counsellors need knowledge of illness from a biological perspective, a level of credibility that is high, and a positive view of medications (Rummel-Kluge et al., 2008, p. 360). We can look to the “Standards of Practice” (Canadian Counselling and Psychotherapy

Association, 2008, section Standards of Practice, para 1) in counselling work when seeking knowledge of best practices for a clinical peer counselling program, which would also incorporate peer values. These standards were set as guidelines to support counsellor self-regulation, public protection, and guide ethical delivery of care and ongoing counsellor education (para. 2-5). These standards include respecting client human rights, personal responsibility of the counsellor to maintain their well-being, setting boundaries to practice within their counselling competencies, and seeking out supervision for their counselling practice (para. 6-19).

In regards to peer services, “growth is uneven across the provinces at the levels of policy, funding, development and provision” (O’Hagen, Cyr, McKee & Priest, 2010, p. 9). According to Bartone, Bates, Brown, Money, Moore, and Roener, (2011), a successful peer program needs proper planning, clear policies, screening of workers, support for workers, and structured training initiatives (p. 2). The policies should include definition of proper boundaries and a confidentiality agreement (pp. 9-10). Furthermore, Bartone et al. stated that in order for peer programs to be successful, they need to develop best practices/ policies that include social supports, experiential knowledge, a sense of trust, confidentiality, and ease of access (pp. 14-15). Not only are policies important, but so is evidence-based practice for any peer program. In regards to peer support programs, O’Hagan et al. (2010) stated, “The move towards an evidence-based mental health care system creates many challenges for the peer support movement” (p. 41).

Healthcare Canada has established reporting guidelines and jurisdictional reporting processes for healthcare delivery. As explained by Broemeling, Watson, and Wong (2009), “Information often needs to be aggregated, measured and reported on a regional basis, because

the governance and accountability structure of Healthcare Canada—as established through legislative authority—is assigned to geographic regions” (p. 43). Peer programs fall under these same guidelines and need to adhere to jurisdictional and national reporting standards.

The authorities who establish best and promising practices in the arena of persons with disabilities have a responsibility to create accessible and human rights-oriented opportunities to this demographic of people. In regards to promising practices in the independent living field, Malloy and Otto (2006) stated, “The independent living philosophy stresses that disability is a natural part of the human condition, and that it is the institutions, policies, and relationships, not the individuals, that must change to accommodate people with disabilities” (para. 1). Future initiatives for people with mental illness in the mental health field also need to be in alignment with this principle. The peer movement is a social rights movement to give people in recovery from mental illness an opportunity to equally access economic, educational, and social resources in their communities (para. 1). All best and promising practices need to keep human rights in mind.

Program evaluation in peer-driven work

Evaluating peer programs is important for their success and must be done thoroughly. In order to capture proper parameters of evaluation, program leads need to assess participation, questions and concerns of the client, counsellor recommendations to clients, length of counselling, and helpfulness of the process (Rummel-Kluge et al., 2008, p. 358). Proper evaluation questions and performance indicators have been considered a priority by makers of policy (Broemeling, Watson & Wong, 2009, p. 41).

At the time of this research, more work needed to be done to allocate resources to evaluate peer programs. According to O'Hagen, Cyr, McKee and Priest (2010),

Resources need to go into the evaluation of peer run initiatives to assist them to keep improving, to refine our understanding of what peer-run initiatives are or need to become, and to build up the evidence base on their effectiveness. (p. 80)

Peer services have value, and evaluation processes could further support their use in health services. Furthermore, "the process of evaluation needs to be seen as integral to the ongoing development of peer support" (p. 80). Peer-led services, whether they support work, research initiatives, or counselling, need evaluative practices that can support the credibility and value of these services.

Organizations running peer services need to evaluate programs and report statistical finding to their funders. Broemeling, Watson and Wong (2009) explained that "information needs to be aggregated, measured and reported at the level of an organization or network of organizations, because these entities are responsible, through contractual relationships, for services delivered to defined patient populations" (p. 43). Service providers must keep in mind to include peers in designing and creating deliverables that matter to their work (O'Hagen, Cyr, Mckee & Priest, 2010, p. 80). Program evaluation will be most effective when people in recovery from mental illness support the process. On a national and provincial level, according to Broemeling, Watson and Wong, "All federal, provincial and territorial governments now support renewal initiatives designed to improve the organization, funding and delivery of these services" (p. 35). Ongoing evaluation contributes to improvements of peer services, which, in turn, enables governments to justify funding them.

Supervision of peer work is necessary for a greater understanding of the work and proper evaluation. Evaluations and feedback could be given to the peer worker to enhance their strengths and give them other options for supporting their clients (Rummel-Kluge et al., 2008, p. 359). Questions and concerns could be addressed and discussed, and answers to problems in the work can be established (p. 359). This supports an evaluation process based on an organizational learning level.

In summary, the peer movement of people with mental illness has been advancing to provide inclusion of this population in the workforce. Best practices and standards of care are being developed around peer support services. Currently, there are a number of peer modalities that enable people to contribute to their communities. More research needs to be done to bridge the gap between professional practice and peer work. Change management processes can support these ideals

Organizational Change

Change management processes enable successful outcomes when implementing innovative programs. By exploring models of change and the role of leaders in change, we can clearly create a path for organizational transformation. The way in which we move forward is to fully understand how change management within organizational settings works.

Organizational change in the 21st century

There are many different types of change to manage including transitional, transformational, and developmental. Each will be discussed in detail in this section. In this regards, Anderson and Ackerman Anderson (2001) stated, “Transitional change begins when leaders recognize that a problem exists or that an opportunity is not being pursued—and that

something in the existing operation needs to change or be created to better serve current and/or future demands” (p. 35). The goal of transitional change is to improve what currently exists and manage it well so people will take action. Anderson and Ackerman Anderson (2001) explained that “transitional change requires the dismantling of the old state and the creation of a clearly designed new, usually achieved over a set period of time called the transition state” (p. 36). This type of change does not just improve what already is; it replaces the old with something different altogether (p. 35). It creates an improved structure in areas where problems or opportunities have been recognized (p. 35).

Transformational change is more complex than transitional change. Anderson and Ackerman Anderson (2001) described transformational change as “the radical shift from one state of being to another, so significant that it requires a shift of culture, behaviour, and mindset to implement successfully and sustain over time” (p. 39). However, transformation efforts can fail. “Dealing with the chaos of transformation creates some interesting and challenging human dynamics” (p. 44). According to Kotter (1996), “Without motivation, people won’t help and the effort goes nowhere” (p. 13). People/resources are extensive drivers of change. “To thrive, the leaders must hear the wake-up call, understand its implications, and initiate a transformation process that attends to all the drivers of change” (Anderson & Ackerman Anderson 2001, p. 39). Leaders need vision and intention to move forward. In transformational change efforts, “they [leaders] begin to formulate new intentions about what is possible and necessary for the organization and its people to thrive” (p. 41). This will motivate and support employees through transformational change efforts.

In contrast, developmental change improves upon existing structures, skills, and standards that are not in congruence with the current needs of the organization (Anderson & Ackerman Anderson, 2001, p. 34). There is no need to get rid of old models and operational strategies. Instead, the developmental model of change adds to or makes better the current way. “Developmental change is the simplest of the three types of change” (p. 34). There is nothing radical in this kind of change. Instead, it adopts small shifts in the current environment (p. 34). One area that often models this kind of change is staff training. Training is a small-scale improvement to staffing needs for the organization. Other areas where developmental change is utilized are team building, feedback surveys, increasing sales, and problem solving (p. 35). Overall, change can take many forms. Whether it is transitional, transformational, or developmental, a leader must recognize which change is occurring and direct the course of action accordingly. They must keep in mind that “one size does not fit all” (Anderson & Ackerman Anderson, 2001, p. 31).

Models and approaches to organizational change

There are many models and approaches to change management. According to Anderson and Ackerman Anderson (2001),

The approach leaders take to transformation impacts every aspect of their change leadership capability and experience, including their personal ability to change, the change strategies they develop, their leadership and decision making styles, their communication patterns, their relationships with stakeholders, their personal reactions, and ultimately, their outcomes. (p. 52)

The different models and approaches to change management include the mechanistic approach and ones that are more organic and emergent. Kotter (1996) focused on the mechanistic model, which included leadership taking a conscious step-by-step approach in any change

process. Furthermore Kotter stated the eight stages of the change process include:

(a) establishing a sense of urgency, (b) creating the guiding coalition, (c) developing a vision and strategy, (d) communicating the change vision, (e) empowering broad based action, (f) generating short-term wins, (g) consolidating gains and producing more change, and (h) anchoring new approaches in the culture (p. 21). If followed correctly, the step-by-step process will have more beneficial results than if stages were skipped: “Skipping steps creates only the illusion of speed and never produces satisfying results” (p. 12). Mechanistic approaches create structure and parameters for the organization to follow in stages.

Another mechanistic approach would be following the model of the “critical path . . . which develops a] self-reinforcing cycle of commitment, coordination and competence” (Beer, Eisenstat, & Spector, 1990, p. 5). This involves engaging the stakeholders in diagnosis of the problem, developing a shared vision, fostering consensus, spreading revitalization, developing policy to institutionalize revitalization, and monitoring/adjusting strategies in regards to arising problems (p. 8). These steps are very similar to those of Kotter (1996) as described in his eight-step model.

On the other hand, Wheatley and Kellner-Rogers (1998) described a more organic model of change management that is very creative and is filled with meaning (para. 1):

If we understand how life organizes, how the world supports its unending diversity and flexibility, we can then know how to create organizations where creativity, change and diversity are abundant and supportive. If we shift our thinking about organizing, we can access the same capacities that we see everywhere around us in all living beings. (para. 8)

This provides an opportunity during change to illicit processes that mirror nature and life in general, thus making them more organic and emergent. The difference between this approach

and the mechanistic approach is the linear versus nonlinear style upon which they are based. It is logic and planning versus creativity and fluidity. In an organic change approach, information shifts, morphs, grows, and changes over time (para. 13). It then overwhelms the organization, causing change to occur (para. 13). The goal here is to allow the organization to re-create itself and reorganize around new beliefs, structures, and ways of being (para. 13).

The role of leaders in successful organizational change

Anderson and Ackerman Anderson (2001) stated, “Change is happening everywhere, its speed and complexity are increasing; and the future success of our organizations depends on how successful leaders are at leading that change” (p. 1). According to Kouzes and Posner (2007), “The work of leaders is change. And all change requires that leaders actively seek ways to make things better, to grow, innovate, and improve” (p. 164). Leaders have a responsibility to motivate their employees to change. A leader must be skilled at supporting each of these areas of employee motivation. According to Kouzes and Posner, “The first place to look before talking to others about the vision of the future is in your heart” (p. 151). Change is more likely to occur through conversations that come from the heart. Employees can be motivated by leaders with heart-centred dialogues. However, Wheatley and Kellner Rogers (1998) stated, “Most communication and change occur quickly, but invisibly, concealed by the density of interrelationships” (para. 12).

According to Anderson and Ackerman Anderson (2001), a change leader “creates change strategy that integrates people, process, and content needs, including how to change mindset and culture to support new business directions” (p. 183). Leaders need to seize the opportunity to make change happen: “Sometimes leaders have to shake things up. Other times, they just have to

grab hold of the adversity that surrounds them” (Kouzes & Posner, 2007, p. 164). Leaders must look externally for opportunities and threats to their organization and create direction that is strategic and clear (Anderson & Ackerman Anderson, 2001, p. 183).

A leader holds characteristics that enable their ability to lead people through change. Studies have been conducted to measure these traits: “No characteristic is universal in these studies, but vision and focus show up most often. Effective leaders help articulate a vision, set standards for performance and create focus and direction” (Bolman & Deal, 2008, p. 345). Along with these characteristics, Anderson and Anderson Ackerman (2001) identified that leaders have seven core competencies: (a) building core organizational capacity, (b) sustaining conditions for success, (c) catalyzing employee commitment, (d) modeling and promoting the change, (e) utilizing process thinking during the change, and (f) integrating employees through strategy (p. 185). Overall, leaders must be skilled and have a planned approach that allows people to adopt change.

Beer, Russell and Eisentat (1990) stated that leaders “defined their roles as creating a climate for change, then spreading the lessons of both successes and failures (p. 3). The lessons of change management are valuable to leaders for future change efforts. Learning from success and failure strengthens the process. Adopting a valuable “Mindset” (Anderson & Ackerman Anderson, 2001, p. 80) or worldview can promote success in the change management process: “Mindset not only influences change leaders’ perception and internal experience, but also their external performance and results” (p. 87). How a leader perceives the change initiative will influence the outcome. Overall, a leader’s role is to implement, communicate, and set the vision

for the change. They do this while motivating employees to shift their own mindsets toward successful change within their organization.

Leaders can influence the outcomes of change management strategies through the approach they utilize: “When leaders take the conscious approach, they have greater awareness about what transformation requires and the strategic options available to them to address its unique dynamics successfully” (Anderson & Ackerman Anderson, 2001, p. 52). However, there is also what has been called a reactive approach (p. 52). This is where leaders enter change management automatically with an unconscious mindset (p. 52). This is based on habit and utilizing their own dominant style. Being conscious during a change management process is defined as “witnessing your experience; reflecting; being alert, clear minded, observant” (p. 53). Being unconscious is having no awareness and not knowing the impact of your behaviour and how you influence others (p. 53). Being a conscious witness to your experience can support your change management planning process: “Furthermore, activating their ‘inner witness’ increases leaders’ ability to notice and stop their automatic habitual reactions to situations that call for new transformational behaviours and strategies” (p. 54).

The human side of organizational change and transitions, trust, and dealing with resistance

Kouzes and Posner (2007) stated, “At the heart of collaboration is trust. It’s the central issue in human relationships within and outside organizations. Without trust you cannot lead” (p. 224). Bolman and Deal (2008) explained, “Change undermines existing structural arrangements, creating ambiguity, confusion and distrust” (p. 383). Trust is essential for change to be successful. Furthermore, employees may doubt their own ability to adopt change: “Lacking

the trust in their own ability to swim, their fall back on trust in their teacher” (Bridges, 1991, p. 78). A leader must model trust to support employees to create change in the organization. “For many employees, however, including middle managers, change is neither sought after nor welcomed. It is disruptive and intrusive, it upsets balance” (Strebel, 1996, p. 86). Managers must be aware of resistance and work toward change any way that incorporates a trusting environment. This will enable employees to adopt change.

Bridges (1991) explained: “*Transition* is the psychological process people go through to come to terms with the new situation. Change is external, transition is internal” (p. 3). Change and transition managed with the aim to support the psychological process can create positive results for all people involved. The old can be deconstructed, and the new adopted. This process can help with employee resistance issues. Another solution to resistance to change includes employee participation in the change itself and understanding the nature of the resistance (Lawrence, 1968, p. 34). Lawrence (1968) explained that there may also be blind spots and employee behaviour that add to the resistance (pp. 34-35). Leaders can utilize a positive approach to motivating employees to adopt change. According to Herzberg (1987), employment hours reduction, spiralling wages, fringe benefits, training, and counselling help employees to lessen resistance and make change happen (pp. 5-16).

Another solution to resistance to change is communication. Larkin and Larkin, (1996) stated, “Senior managers must realize that employees will change the way they go about their jobs only if they learn about what is expected of them from a familiar and credible source” (p. 12). They also stated, “Communication between frontline supervisors and employees counts the most towards changed behaviour” (p. 12). Communicating facts instead of values can guide

employees to change and beat resistance (p. 3). In contrast, if not done well, “Communication breaks down, implementation plans miss their mark, and results fall short” (Strebel, 1996, p. 86). Constant communication is the key to success in times of change. Bridges (1991) advised, “Don’t let communication cease” (p. 118). He also advised us to “seize the communication initiative. Start talking” (p. 118). Without communication, human beings are less apt to make change happen.

Change management processes are guided by “formal, psychological and social” factors (Strebel, 1996, p. 87). The formal factor is guided by employee job descriptions, contracts, and performance agreements (p. 87). The psychological factor is guided by relationship components like trust between employer and employee (p. 87). The social factor is guided by the organization’s values, practices, and culture (p. 88). A leader can influence resistance to change by re-creating and establishing the proper process/vision to nurture a positive atmosphere for these factors.

Adoption of change by employees can be influenced by the organization’s internal environment. Kouzes and Posner (2007) stated, “Some standard practices, policies, and procedures are critical to productivity and quality assurance. However, many are simply matters of tradition” (p. 185). What was done in the past may need to be re-evaluated to serve the future of the organization. This, in turn, can support the employees’ change efforts: “If your organization is going to be the best it can be, everyone has to feel comfortable in speaking up and taking the initiative” (p. 186). The leader has the responsibility to create the best environment to transform the organization and manage transitions. This, in turn, will motivate employees to engage in the change management plan.

Bolman and Deal (2008) stated, “Transition rituals initiate a sequence of steps that help people let go of the past, deal with a painful present, and move into a meaningful future” (p. 391). Bridges (1991) explained that “psychological transition depends on letting go of the old reality and the old identity you had before the change took place” (p. 4). Transitions like these are followed by what is called the “neutral zone” (p. 5). This is the space between the old and the new: a key time for seeking out “creativity, renewal, and development” (p. 5). “Symbolically, leaders can construct a persuasive story by painting a picture of the current challenge or crisis and emphasizing why failure to act would be catastrophic” (Bolman & Deal 2008, p. 394), which can motivate people to act and get them through the neutral zone.

In summary, the differences between transitional, transformational, and developmental change as types of change have been described. I explored the way leaders can work with stakeholder resistance through communication incorporated into process strategies, both in a linear and organic manner. Managing the people involved takes skill and precise measures to create a smooth change transition.

Chapter Summary

In summary, it is important to acknowledge there is a distinction between peer support and peer counselling. However, they come from the same principle of utilizing lived experience to help clients. The goal in both types of client care is to empower the client and share an understanding of the struggle to recover from mental illness. Peer support is gaining credibility on a national scale. Policies and research documents back up its effectiveness and lead the way to their further development in regards to clinical peer counselling practice.

There are numerous practices, policies, and standards that govern client care in healthcare settings. There will be opportunity to advance the peer movement through additional research and instituting promising practices that have yet to be established. Program evaluation and reporting processes can enhance peer programs and create a potential for future support from funders. Overall, clinical peer counselling needs to be solidified as a viable program, with the development of its own set of standards that fit with both professional and peer-service policy. In this regard, understanding of the dynamics of various types of change and effective change management strategies is required if organizations are to change mindsets and perceptions of peer work to ensure supportive employee adoption of change and allow leaders to influence the process of change itself within their organization.

In the next chapter, I will introduce the inquiry approach, participants, methodology, and methods. This includes interviews with two experts and five BCSSV board members and a focus group that engaged the board in focused dialogue on the inquiry topic of peer counselling. The action research process for this project will be explained in full.

CHAPTER THREE: INQUIRY APPROACH AND METHODOLOGY

The overall inquiry approach, participant choice, methodology, methods, and the research process are explained in this chapter. It discusses the ethics involved and any power differentials between those involved. Furthermore, it describe how the participants were engaged through ownership over the results, actions taken, and personal reflection over the entire process. The research questions that the BCSSV explored were as follows: How can the BC Schizophrenia Society Victoria develop a credible and viable peer counselling program? Sub questions included:

1. What resources are currently available for peer counselling and what gaps in resource requirements exist that would need to be addressed?
2. What client needs could a peer-counselor address, which are not met in the current peer support program?
3. What benefits exist to the development of a peer counselling program?
4. What risks could BCSSV face in introducing peer counselling and how can these be mitigated?
5. What implications do these findings have for the broader application of peer counselling by other non-profit community organizations whose purpose is to support those with mental illness?

Inquiry Approach

My overall research was grounded in a qualitative approach. I used an action research methodology, which is a process of working in collaboration with organizational stakeholders to develop a research project that encompasses idea formulation, data analysis, and co-planning.

The action research process was described by Wamba (2011) as follows:

We did not intend to achieve consensus in our conversation but rather to emancipate ourselves from preconceived ideas, commit to continue learning, and in the process learn about ourselves and other people. By engaging in an action pedagogy, we integrated dialogue and critical thinking, striving to maintain a community even when we disagreed with each other. (p. 173)

This quote took me to the very heart of the action research paradigm and my organization. We were on a journey of building knowledge, learning from each other, and understanding the world in relation to the inquiry questions. Reybold (2002) explained that “the personal model of self is more than a mental construct or ideology; it produces behaviors and actions that correlate to ways of knowing. This concept of pragmatic epistemology situates knowing in the life world experiences of everyday reasoning” (p. 547). My research followed this lens in its application. Furthermore, according to Glesne (2011), “You must be able to distinguish the line between your passion to understand some phenomenon and your over involvement in very personal issues that need resolution” (p. 29). It was important that my passion for the research topic did not colour the lens of empathic support of the research process. Stringer (2007) introduced the following as an action research protocol: “Active participation is the key to feelings of ownership that motivate people to invest their time and energy to help shape the nature and quality of the acts, activities, and behaviors in which they engage” (p. 34). Overall, as an empathetic researcher, the process I utilized engaged participants, motivated their contributions, and provided a feeling of ownership over the end result.

The methods I utilized to co-create the action research process included interviews and a focus group. The action research cycle was to plan, act, observe, and reflect (Stringer, 2007, p. 8). Furthermore, there were many theories, belief structures, and ideologies that created our organizational research reality. As a researcher, I proceeded with skilful “empathy” (Reybold, 2002, p. 548) for the people involved, which helped facilitate our ability to build transformative relationships.

Participants

Participants in this action research on peer counselling within the mental health field included the BCSSV Board and two peer service experts not associated with the BCSSV. The participants were selected to support a diverse range of expertise in the mental health field, from personal recovery, family and professional experience. The following sections explain in detail each segment of the population that contributed to this research process and the methods in which data were collected from them.

External experts interview participants

The first participant group for my action research thesis were two experts in peer services who work outside the BCSSV. These experts were chosen purposively so as to capture the knowledge of established experts in the peer field. I chose to interview only two experts to enhance the quality of information gathered, as those selected had an abundance of relevant knowledge and experience to create richness to the research process. Each was sent a letter of invitation to participate in a telephone interview (see Appendix A for letter of invitation for expert's interview).

BCSSV's Board of Directors

The second and largest participant group included organizational stakeholders within the BCSSV as represented by the organization's 14 board members who came from diverse backgrounds. Some were family members of people with mental illness, and two members were in recovery from mental illness themselves. There was also a broad range of professionals with backgrounds in the fields of nursing education, law, group home management, and occupational therapy.

I chose to exclude the BCSSV clients in recovery from mental illness and family members who have accessed our services other than those sitting on the Board of Directors. I made this choice at the request of the BCSSV Board members for three reasons: (a) to contain the research process, (b) to involve only stakeholders that I do not have power over in my role as administrative coordinator, and (c) to reduce the amount of risk to the organization.

I also excluded the BCSSV staff, including the peer support workers who were part-time employees. The BCSSV Board supported the inclusion of board members, which represented family members, people in recovery, volunteers, and professionals. Although staff members had been excluded, the Board was sufficiently diverse to capture relevant information. Additionally, some Board members had been staff within other organizations in the mental health field. Although including the BCSSV staff and clients may have contributed a broader range of data and allowed people who have “been there” vis a vis having a mental illness to play a meaningful role), the Board represented a segment of our population that was sufficiently diverse to collect the views of these diverse stakeholders. I made sure to answer any staff questions that arose regarding this research project in an open, honest, and authentic way. This hopefully mitigated any concerns the peer support team, other clients, and their families may have had about being excluded from participation.

Each Board participant received a letter of invitation for both an interview and a focus group (see Appendices B and C). All participants contributed to the exploration of the inquiry topics through planned, informed, and agreed-upon means. This agreement was in written format through the signage of an informed consent form for the experts and board members to

participate in the interviews (see Appendices D, E, and F for the experts and board informed consent forms for the interview and focus group participants respectively).

Board of Directors interview participants

For the interview portion of the action research process, board member participants were chosen through random sampling from each of the three sub-groups represented on the Board. I randomly chose a total of five board members representing three stakeholder groups. The board members chosen, by stakeholder group, included a family member, a person in recovery, and three professionals. I undertook this random sampling by putting the names of all members of each of these sub-groups into a hat and drawing one name from the family member sub-group, one name from the persons in recovery sub-group, and three names from the professionals sub-group. I sent out an initial five invitations to board members to participate and awaited acceptance of the invitation. The subgroups of Board participants (i.e., family member, person in recovery, and professionals) were represented more than once by multiple board members. All the invitations were accepted, and all stakeholder groups were represented. This broadened the data collected by including multi-level stakeholder knowledge.

Board of Directors focus group participants

By utilizing a focus group method in my action research, data were further enriched. The invitees included all 14 BCSSV board members, including those five who had already served as interview participants. The board members were my superiors, and all the interview participants were either my equals or more senior in responsibility in their various organizations.

All these stakeholders were invited to participate with the choice to decline. The letters of invitation for both the interviews and the focus group explained that the board members could

decline to participate at any time during the process (see Appendices B and C). Upon arrival at the focus group location, board members were reminded that they could withdraw at any time in the process. It was explained that they had the right to not participate. I offered debriefing after the focus group to anyone who needed support due to declining to participate.

Inquiry team

My action research inquiry team included two of my Masters of Arts in Leadership Health (MALH) cohort members. They were not research participants, but rather functioned as members of my research team. These individuals were chosen to support the action research process and my learning due to their familiarity with the research process and Royal Road University's action research requirements. They had no power over the research participants due to the nature of their relationship as co-students working outside the BCSSV. The inquiry team members signed a letter of agreement that included a confidentiality clause (see Appendix G). My inquiry team supported my thesis work through phone conversations if I needed support on any given part of the process, sharing knowledge on the process, reviewing drafts of letters and protocols, writing flip chart notes at my focus group, and providing resources as needed.

Inquiry Methods

The purpose of this section is to describe the methods/strategies involved in the inquiry's interview and focus group processes. The goal of using interview and focus group methods was to find substantial data in the area of peer services and to distinguish between peer support and peer counselling. In keeping with the participatory nature of action research, the BCSSV aimed to support all processes involved in the data collection, analysis, and the ethical conduct of the project. As this was an evidence-informed and qualitative action research project, we worked

towards uncovering new information/direction. Using these methods helped to build trustworthiness and authenticity in the research process. Both I, as the researcher, and the participants had a responsibility to maintain this level of integrity. As we engaged in honest and open dialogue, we came close to establishing a team of decision makers who could implement action items.

Data collection tools

Through the interview and focus group methods, questions were asked to focus participants on understanding concepts and obstacles to implementation of a peer counselling program. According to Glesne (2011), this is called “topical interviewing” (p. 104). As explained by Wheatley (2006), “For several decades now, there has been a growing chorus of research and practice that sings the praises of participative management” (p. 163). This was the basis to my study conduct. Involving the participants in the management of their knowledge sharing helped them gain higher levels of buy-in. The participatory approach honoured the partnership between researcher and the participant group. The dialogue engaged the participants in conversational data gathering that they themselves owned.

All questions aimed to reduce the amount of researcher bias and potential to lead the participants to a particular answer. As a researcher, it was my responsibility to allow the process to unfold without holding on to the outcome that would uphold my bias. This was addressed through self-disclosure and piloting the questions being asked prior to the study. Chenail (2011) stated,

Instrumentation rigor and bias management are major challenges for qualitative researchers employing interviewing as a data generation method in their studies. A usual procedure for testing the quality of an interview protocol and for identifying potential

researcher biases is the pilot study in which investigator's try out their proposed methods to see if the planned procedures perform as envisioned by the researcher. (p. 255)

Interviews

The method of interviewing was chosen for the degree of personal connection it creates with the participants. According to Glesne (2011), "The specifically therapeutic aspect about the interview process is the unburdening effect on the respondents' saying safely whatever it is they feel" (p. 123). This was in alignment with the nature of our mental health non-profit culture of supporting our stakeholder groups. The candid information gathered from the interviews served to inform the development of questions and focusing themes for the second phase of the inquiry: the focus group. Stringer (2007) advised that:

Interviews provide opportunities for participants to describe the situation in their own terms. It is a reflective process that enables the interviewee to explore his or her experience in detail and to reveal the many features of that experience that have an effect on the issue investigated. (p. 69)

The external experts were asked their own set of relevant questions that related to their field of work in peer service (see Appendix H). The questions focused on national structures for designing peer service, development of peer services processes and policies, barriers to disclosure of mental illness in clinical work, social justice and peer work, and future trends in peer service as they saw it. I utilized a semi-structured approach, and both experts were asked the same questions with additional probing questions that arose during the interview.

The board member interviews focused on personal and professional experiences with peer work and the development of a peer counselling program within the BCSSV. I used a semi-structured technique, where all the participants were asked the same questions as set by me, the interviewer; yet, there was room to ask supplementary questions as necessary. The additional

questions were utilized to explore thoughts and ideas that the participants uncovered during the research method process. Rose (n.d.) posited:

Using unstructured and semi-structured interview techniques thus demands that you be open-minded and willing to follow where your informant may lead you. Semi-structured interviewing, therefore, contains an element of adventure, a step into the unknown, into the life and feeling of another human being. (p. 2)

The board member interview questions were finalized once the results of the interviews with the external experts were examined in the event that there were new or different questions that should be asked. The resulting interview questions were pilot tested with my inquiry team to make sure they fit the research process for gathering the best data, were suitable to the participants' backgrounds, and did not leave gaps pertinent to the research question (see Appendix I).

Focus group

The second method I used to collect data was a focus group. According to Eliot and Associates (2005),

Focus groups can reveal a wealth of detailed information and deep insight. When well executed, a focus group creates an accepting environment that puts participants at ease allowing them to thoughtfully answer questions in their own words and add meaning to their answers. (p. 1)

Focus groups also enable high-level involvement by multiple people to create potential change. According to Norton (2003), "High involvement by all is critical to any deep, institutional change endeavor" (p. 287). The BCSSV board members acted as co-investigators and were encouraged by each other's contribution to the focus group. The focus group questions and protocols were pilot tested utilizing the support from four of my MALH program cohort (see Appendix J).

Interviews and focus groups complement each other in that they support dialogue that enhances understanding of the inquiry topic: “It is not until you have had an encounter, become engaged, and developed your own personal feelings and beliefs about a situation, that you have actually gained personal knowledge through the experience” (Hammick & Wade, 1999, para. 7).

Through the cyclic nature of this qualitative action research, there was opportunity to deepen knowledge sharing and understand the nature of the topic through strategically planned and pilot-tested questions and protocols prior to moving forward. The preliminary analyses of the interview data collected aided in forming the focus group questions to deepen the dialogue amongst our stakeholders.

Study conduct

The processes to be put in place for conducting the research included recruitment and orientation of inquiry team, pilot testing of interview questions and protocol, inviting and securing informed consent from interviewees, and conducting of the interview. It also engaged in enhancing authenticity and trustworthiness. Details of each process are presented in this discussion.

Recruitment and orientation of inquiry team

Potential inquiry team members were approached in the first stage of the study conduct. I recruited two of my cohorts from the MALH program. As they were external to the BCSSV organization, they did not have power over any of the participants. Upon agreeing to participate in this capacity, I oriented them to the research questions, background, and other roles. I also answered any questions they had, after which they signed a confidentiality form that I had incorporated into a letter of agreement (see Appendix G).

Pilot testing of interview questions and protocol

The external expert interviews were pilot tested with a member of my inquiry team and two additional classmates. I hosted a pilot telephone interview to test the recording equipment, timing, and process. This was done long distance to ensure the process duplicated the actual process to be used with the experts. I spent an hour on the phone with my inquiry team asking the questions that were predesigned. The goal was to gain feedback and make improvements on the process (see Appendix H for the external interview protocol and questions).

The next stage was to pilot test the internal board member interview questions, protocol, and recording device. The test interviews were hosted at the home of one of my inquiry team members for ease of implementation of the pilot test. The plan was to host a mock interview with each of my inquiry team members to solicit feedback to move forward with edits and/or adjustments to the questions, the protocol, the recording equipment, or all three based upon these pilot tests (see Appendix I for board member interview protocol and questions).

Inviting and securing informed consent from interviewees

The experts whom I interviewed were sent the informed consent form (see Appendix D) by email and were required to email a signed copy back to me. This was done after they accepted the terms of participation and agreed to be a part of the study. When we were ready to begin the research process with the board participants and they had accepted their invitation, I sent an informed consent form by email to be signed and brought to the interview session (see Appendix E). Questions about the form were answered as they arose. I also had blank copies of the form at the interview session in case one of the interviewees did not bring the form with them.

Conducting interviews

The interview process through which this research was conducted is described in this section. Interviews were planned and implemented to collect data on the topic of developing a peer counselling program. With the addition of experts in the mental health field who understood the current peer program status in Canada, the data were enriched. The BCSSV board stakeholders who were interviewed also contributed a rich knowledge base for this project. The interview structure and preplanning stages to prepare the participants are explained below.

External expert interviews

I called the experts long distance and paid for all charges myself. The interview questions were sent prior to the interviews. I read from the draft protocols to explain the interview process to the expert interviewee (see Appendix H for external expert interview protocol and questions). I confirmed that I had their consent form prior to the interview commencing. I explained that they would be on speaker phone so I could record the interview. They were told that the recording device could be turned off momentarily if they needed to edit a comment. The interviews each lasted 60.13 minutes and 54.57 minutes.

Board member interviews

All interview questions were sent out prior to the commencement of the interviews. The interviews were held in the meeting room at the BCSSV. I offered water and tea to the participants to create an atmosphere of care and empathy. I had them confirm their consent and informed them they could withdraw at any time and that they could request that the digital recorder be turned off for any part of the interview before being turned on again. I used a soft and warm tone of voice as is customary of the BCSSV culture in working with staff and clients.

Each interview lasted between 48.26 to 55.43 minutes. Each question was asked with enough time for the participant to fully contribute their knowledge and ideas (see Appendix I for the board member interview protocol and questions).

The closing of both sets of interviews was strategically planned to allow for any residual thoughts, ideas, and feelings to be expressed. The participants were thanked and reminded that they would receive a copy of their interview transcript to review for accuracy and completeness within 48 hours. I asked them to provide me with any edits to their transcript to confirm accuracy. An external transcriptionist, who signed a confidentiality agreement (see Appendix K), transcribed the data. I disclosed to the interviewees what would be done with the information gathered. Then, I proceeded to collect contact information so the transcript and the final report could be passed on to them.

Finalization of focus group protocol and questions

Once the interviews were completed and the data checked for accuracy with interviewees, these data were analyzed and categorized into themes. Once this had been done, I took the data to my inquiry team for review. With their feedback, I re-examined the focus group questions and utilized the interview data to inform their re-design. These new draft questions were pilot tested with four of my MALH class members. They were invited to attend a focus group at the BCSSV office to test the process, questions, and recording equipment. I asked for feedback on all of these items to inform and finalize the research focus group process. I tested the note-taking piece of the focus group as well. My inquiry team members were selected to manage note-taking for the flip chart documentation.

Invitation and informed consent for focus group participants

While I piloted tested the methods, an email was sent to each of the board members inviting them to participate in the focus group (see Appendix C). The informed consent form was sent once they agreed to participate (see Appendix F). All participants were required to sign this form before the focus group began. Once again, I had copies available at the focus group for those who had not already done so to sign. I chose a day for the focus group to begin, but had only two board members say yes to participate. So, I cancelled that focus group and held a Doodle poll in which I picked six days that the board members could choose from. Two days had my minimum requirement of five board members, so I chose a day that my classmate could help with flip charting ideas and themes.

Conduct of the focus group and member checking of transcript

The focus group was planned to last approximately an hour and 20 minutes and actually ran for 106.29 minutes. Coffee and a light snack were provided to help the participants feel comfortable. The chairs were placed around the room in a focus group. The session was tape-recorded using two recorders to ensure accurate and complete capture of all comments. My inquiry team member recorded information on the flip chart board. Board members took turns speaking as thoughts arose. I, as the moderator, encouraged participants to contribute. The use of a talking stick supported a safe and one-at-a-time style of speaking. The focus group was closed with a final comment from each participant regarding the process they had just engaged in (see Appendix J for the focus group protocol and questions)

The focus group was held in the BCSSV boardroom, which provided a secure, private, and quiet location. The door was locked, and a sign saying “room is occupied” was posted on the

door. It was held after hours on an evening when no one else would be using that part of the building. The front door to the office was also locked to minimize interruptions from outsiders.

Enhancing authenticity and trustworthiness

All participants were told that if questions arose, they could contact me at any time. I made myself available for conversation and provided my contact information to each participant.

As noted by Berstrom (n.d.),

Process consultation is a difficult concept to describe simply and clearly. It is more of a philosophy or a set of underlying assumptions about the helping process that lead the consultant to take a certain kind of attitude towards his or her relationship with the client. (p. 9)

I utilized the process consultation approach when engaging with the participants. This included being aware of my assumptions while asking questions or focusing the focus group participants. I always took a helpful approach and was in touch with the current reality of the organization. As the facilitator researcher, I understood my ignorance and gave over ownership of this process to the participants (Berstrom, n.d., p. 3). It took a degree of humility to host interviews and a focus group. The conduct of this study needed to centre on not me as the expert, but on the participants as the knowledge bearers, the goal being to diagnose and explore the issue and implement a change management strategy to act on the recommendations that the participant data uncovered. Member checking of all transcripts with participants further ensured the accuracy and completeness of the data prior to their analyses.

Data analysis

The interview participants were assigned letters of the alphabet (i.e., Participant I-1, Participant I-2, etc.) for identification purposes within their transcripts. For focus group

participants, the transcripts reflected the pseudonym each participant selected at the beginning of the focus group. As well, prior to analysis of these data, the transcripts were anonymized to remove the names of any individuals and/or any references that could result in the participant or a third party being identified.

The style of data analysis combined a narrative and thematic approach. In this regard, I looked at the data for the organizational story. I tried to understand where the tensions, patterns, and cultural norms resided. I made my analyses rich with details of what was said by participants so the reader can see the research context fully. Glesne (2011) advised that:

Data analysis involves organizing what you have seen, heard, and read so that you can figure out what you have learned and make sense of what you have experienced. Working with the data, you describe, compare, create explanations, link your story to other stories, and possibly pose hypotheses or develop theories. (p. 184)

Throughout the data analysis processes in search of themes and associated sub-themes, there was opportunity for peer review and debriefing with my sponsor and inquiry team as a means of checking my own interpretations against those of others. In this way, iterative cycles of sorting and re-sorting were undertaken, at all times attending to the voices of my participants as the tangible evidence to support each theme discovered within these data. The data collection needed to be backed by sound and ethical practice that adhered to Royal Roads University (2011) standards.

Ethical Issues

The action research I implemented with my organization underwent a rigorous ethical review through Royal Roads University. Furthermore, the process adhered to a high level of integrity in accordance to Royal Roads University's (2011) *Research Ethics Policy*:

All research and scholarship were carried out in accordance with the Tri-Council Policy Statement on Integrity in Research and Scholarship, the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans, BC Freedom of Information and Protection of Privacy Act and other applicable privacy legislation, codes and policies, and Requirements for Certain Types of Research. (p. 1)

According to the policy statement of the Canadian Institutes of Health Research, National Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada (Tri-Council; 2010), “Respect for human dignity requires that research involving humans be conducted in a manner that is sensitive to the inherent worth of all human beings and the respect and consideration that they are due” (p. 8). The three core principles of the Tri-Council (2010) policy are listed as “concern for welfare, respect for persons, [and] justice” (p. 8).

Concern for welfare

Through due diligence, I minimized any negative impact, risk factors, and effect this research process could have had on the participants’ quality of life. This was supported as each participant remained anonymous in the final thesis report. Participants were provided with enough information on the project to understand risks and benefits of the research process for the organization and for themselves. Any personally identifying details were kept out of the study (i.e., age, cultural background, religion, and gender) to protect participant welfare. The participants’ names were not used, and they were assigned letters of the alphabet and an Arabic number to identify their voices on the recordings. The participants were asked at the beginning of the focus group to respect the confidentiality, contributions, and identity of all others present in the room. They were asked to not discuss or otherwise disclose any of the dialogue to anyone who was not involved directly in the focus group.

The BC Schizophrenia Society of Victoria did not require its own ethical review. I did not collect personal health data or use the collected information for untoward means. All information collected and the identity of the participants remained confidential and was placed in a secure, password-protected or locked storage place. Transcripts were anonymized to prevent any direct or indirect identification of participants or other third parties referred to by the participants. I will keep the data for one year following the research project, at which point it will be destroyed.

Respect for persons

Respect for participants was the ultimate goal of the research process to protect their well-being and autonomy. The overarching values of respect for person associated with this research project included honesty, choice, integrity, and safety. This research project remained transparent and authentic, and I engaged participants in safe exploration of the research topic. In order to recognize the participants' autonomy, I supported them to act based on their own deliberations (Tri-Council, 2010, p. 8). The Board had access to the proposal prior to beginning the process so that they could research the topic area and be informed enough to answer questions if they choose to be involved. All interview and focus group questions were sent out prior to the commencement of the data collection method. If a board member had a mental illness and required an advocate, such as in regards to signing informed consent forms, I supported them to find an advocate of their choosing.

Each participant was sent a fully disclosing letter of invitation to volunteer (see Appendices A, B, and C) and asked to sign a consent form in order to be a participant in the research process along with the assurances that they were free to decline to participate as a

volunteer without prejudice (see Appendices D, E, and F). These forms ensured that they were able to give fully informed consent and that they were aware of and agreed to the details of the terms of the research project. All participants had the choice to withdraw at any time, and all data contributed by them during the interview or focus group were destroyed if the withdrawal occurred prior to the analysis of data. If the participant withdrew after the data had been analyzed, the information they contributed was kept as a part of the research project.

Justice

The BCSSV Board was made up of members with diverse backgrounds. Some of the board member participants for this research project fell under the vulnerable population category (Tri-Council, 2010, p. 23). This was due to them being in recovery from mental illness. They were chosen to participate because they were capable as current members of the board and would inform the project from a peer perspective. They had worked, volunteered, or been through the mental health system as a client. To affirm the justice principle in this case, I treated them fairly and equitably throughout the process. In the focus group, the burden of the research responsibility was distributed evenly to all board members present. They had an opportunity to be supported more so than other board members without mental illness. Their time, disability, and contribution were honoured and respected for the differences they brought to the table. If they had any needs beyond the focus of the group or interview format, I accommodated them or found a resource to get those needs met. The research process met all ethical standards including justice processes.

Chapter Summary

Overall, the inquiry approach, methodology, and processes in place to institute this action research project were discussed in this chapter. The choice of participants met the standard of diversity that the BCSSV both supports and nurtures. Experts were consulted through an interviewing strategy to heighten the quality of data collected externally to the organization. Ethical standards were followed, and inclusion measures were met with a high degree of practice. The researcher bias was explained, acknowledged, and set aside for the purposes of the study.

In the next chapter, I discuss the findings of the data collection in detail. The researcher analysis will be enhanced by quotations of the participants from the interviews and focus group. All discussion will support the organizational goals and recommendations for further action items within the BCSSV. Several perspectives will be utilized and will inform the overall change management direction of the organization.

CHAPTER FOUR: FINDINGS AND DISCUSSION

This research was conducted with board members of the BC Schizophrenia Society Victoria (BCSSV) and two experts holding valuable insights and knowledge of peer led services in the mental health field, to explore a new area of peer programming. The research question was as follows: How can the BC Schizophrenia Society Victoria develop a credible and viable peer counselling program? Sub questions included:

1. What resources are currently available for peer counselling and what gaps in resource requirements exist that would need to be addressed?
2. What client needs could a peer-counselor address, which are not met in the current peer support program?
3. What benefits exist to the development of a peer counselling program?
4. What risks could BCSSV face in introducing peer counselling and how can these be mitigated?
5. What implications do these findings have for the broader application of peer counselling by other non-profit community organizations whose purpose is to support those with mental illness?

Wheatley (2006) so eloquently described my experience of performing this research as: “Systems influence individuals, and individuals call forth systems. It is the relationship that evokes the present reality. Which potential becomes real depends on the people, the events and the moment” (p. 36). This research, from which arose a selection of rich data on the subject matter, has been about individuals calling forth their systems knowledge to create a potential reality for BCSSV.

Findings

The following is a synopsis of the data collected from seven interviews and a focus group. All data are based on transcribed and flip-charted information that was member checked

by the participants. The findings were diverse in nature yet also showed some overarching themes/subthemes that were applied to the research focus.

Response rates

Overall, I approached four experts in the mental health field, two of whom agreed to be interviewed for a response rate of 50%. Both of these experts came from a recovery-oriented or human rights research background and had extensive knowledge of peer services. They provided similar ideologies and rich data that enhanced the content of this research project.

For the board members' interviews, I sent requests to all 14 of the BCSSV board members. Of those, five board members stepped forward to be interviewed for a response rate of 36%. Of those five, three were people in recovery and two were professionals having worked in the mental health field for a number of years. Of the people in recovery, all three were also family members of someone with a mental illness. One of the professionals also had a family member with mental health issues. The reasons board members could not attend ranged from being on holidays, being out of town, having a prior engagement, or having the flu.

For the focus group, I sent out 14 letters of invitation to the BCSSV board members and received confirmation from only 5 board members. The focus group garnered a 36% acceptance rate to participate in the research. Of the 5 board members who participated 3 were professionals in the mental health field and two were people in recovery from mental illness. Of the five participants, three also had family members with mental illness. Of the five board members who participated in the focus group 4 had also participated in the interviews.

In the reporting of findings below, quotations from the experts in this research project were coded as E1 and E2. The board member interview participants were coded as I-1, I-2, I-3,

I-4, and I-5. The focus groups participants were coded as FG1, FG2, FG3, FG4, and FG5.

Throughout this thesis paper all participants will be addressed by this coding system as to protect anonymity.

Thematic analyses

After careful analysis of all the research data from the interviews and focus group, a number of themes were discovered. The overarching themes were: ethics, clarity before action, the need for structure, and the “two sides of the coin” of peer counselling. Subthemes in some of these themes included: ethics and peer employment, disclosure, boundaries, human rights, establishing philosophy and definitions, determining readiness, innovative models, training, supervision, recruitment, liabilities, and strengths. Each of these themes and their associated sub-themes will be presented in this chapter along with the supporting evidence from the data that led to their identification.

Theme one: Ethics and peer employment practices

According to the participants’ data, the overarching theme of ethics was a well-discussed topic area. The idea of ethical practice in the field of peer work arose regarding levelling any power imbalances between the peer counsellor and the client. Participants expressed that BCSSV would need to adhere to ethical standards in the field of counselling while creating the proper boundaries within the peer-to-peer relationship. According to participant FG2, “I’ve never been a peer counsellor or a counsellor. But there are some professional ethical standards that the counsellor would need to adhere to”. In regards to adoption current national standards, E2 stated,

Some organizations are beginning to adopt the workplace psychological safety standards. . . . I know that there have been a number of organizations or companies that have said they’re going to take this seriously and develop new policies and practices around it.

Ethical and well-thought-out strategies to deal with boundaries, power imbalances, peer personal story disclosure, and professional and safety standard adherence reflected the direction the participants supported overall. This is discussed below.

Ethics and employment practices

Ethics and peer employment practices in hiring peer workers and involving peers in research, program design, and innovation were identified by participants as an ethics-based social justice issue as well. E2 explained, “Depending on policies, again, which we referenced [to] earlier on in the discussion, a recovery-oriented mental health service should not be afraid and is not afraid of advocacy or human rights and dignity issues. That’s part of the recovery process”. This expert interviewee expressed that opportunity to participate in peer-led services needs to be provided at multiple levels of care to a diverse range of people with mental illness. In regards to the BCSSV and the recovery philosophy, E2 also stated,

It has to have the values of self-determination, hope, empowerment, and choice. It has to have people with lived experience on its board and hire people with lived experience, and then it cultivates peer support workers, and again you can have a various spectrum of peer support workers.

E2 also stated,

Communities of support that are inclusive only of people with mental illness are starting to open that up and recognize that social inclusion in the broader community is a vital goal and that peer support needs to move towards being a bridge to broader inclusion in community as opposed to isolated communities of support.

Currently, BCSSV has a peer support program wherein the workers are paid staff, which brings them to a higher-level role with more expectations from our organization. Many of our past clients have moved on to work within that program. Ethically speaking, however, participant I-5 explained,

I think we need to be careful that we don't see every person that walks through the door that has an illness as wanting to be a peer support worker. Hopefully those people want to be lawyers, or they want to go back to school and study whatever, and somehow there is a way we can support them in their unique vocation.

Similarly, FG5 stated, "Another thing that brought up a red flag for me is putting limitations on the severity of illness and the degree of illness that the peer counselors might have experienced".

FG5 further stated, "It's a big deal to make sure clients are safe and the peer relationship is a safe relationship. I just think it's very close to discrimination at one point or another".

In the development of a peer counselling role where the counselor is to help clients through unraveling their stories, it was suggested to keep in mind the issues that surround boundaries and personal disclosure of having a mental illness. Participants explained this is important to establish before proceeding with the development of a peer counselling program.

The topic of disclosure is explored in the next section.

Disclosure

Participants found that disclosure can be a strength in peer relationships that supports the recovery process; however, power imbalances that exist in professional work most often warrant a non-disclosure approach. For example, Participant I-5 expressed the following concern:

I think the power imbalance that currently is so prominent between the client-psychiatrist relationship . . . is really intense. From being a client myself, . . . there is a greater level of comfort when you're talking to someone who has been where you've been. . . . I also feel that in a peer relationship, there's another layer of knowledge that wouldn't necessarily be in a professional relationship. Life experience is so valuable and so amazingly beneficial to share.

Participants agreed the insight and knowledge of recovery that people in recovery have would be the main ideology of peer counselling, yet the program needs an ethical basis for disclosure

through which to support the client. There was mentioned, however, a downside to disclosure as a professional. E1 explained this as follows:

I knew that if I disclosed either my family experience of mental illness or my own, I'd be kicked out of the club. You know very, very quickly that it is not accepted. You are either one of us or one of them.

It seemed to this expert interviewee that professional boundaries around non-disclosure are very heavily enforced. E1 further explained:

The upside is that when you have embedded in the system people who are formally sitting there as consumers who are playing the role of vocalizing that perspective, it changes the way people talk. . . . Consumers who give voice to their concerns about treatment actually empower, ironically, health care professionals to speak up, because they experience the same dissonance.

It was clear from this participant's experience that disclosure changes systems; peers change systems and enable professionals to be professionals to be 'ambassadors' and 'champions' (E1) for recovery. This individual invited others to imagine what it would be like if disclosure were an accepted part of professional work. Participant FG4 added the following to this topic area: "It's funny how some psychiatrists or RPNs themselves suffer from a mental disorder. So without revealing, they are themselves peers". Further to this ideology, E1 shared:

There's quite a bit of research that's coming out of when a psychiatrist discloses to a client that they share this experience, how they do that, and how that helps a therapeutic relationship and when it gets in the way.

That said, E1 did not agree that a disclosed peer counselling role would be helpful or should be developed at all. As explained by E1, "I think it creates a murky confusion of roles and responsibilities and boundaries, because you move into one role when you're comfortable and you move out of it when you're uncomfortable". Participant I-1 also had mixed sentiments regarding disclosure in a professional setting, and stated,

Disclosure, I think . . . if it's a person in a very professional role and they disclose, there's a danger of losing the professional status. Although I see it as a huge benefit to disclose, there are certain boundaries that people need at times, depending on the relationship.

This interviewee (I-1) further described that when academic professionals talk about personal details, it can compromise the relationship with the client. Participant I-2 offered a similar ideology: "It might be a crossing of boundaries by the peer counsellor to unburden or share with the client". This interviewee also understood, "If the peer counsellor does disclose, it may make the client say, 'Hey, I tended to view them as having more knowledge and some degree of power over me, but look, I'm reminded that they . . . have a similar illness'" (I-2). Participants observed that this type of disclosure might then create a sense of equality in the peer counselling relationship. Participant I-4 stated, "For many clients, people living with mental health issues, particularly schizophrenia, somebody who's had that lived experience is going to be able to help the client in a different way to somebody without that experience". So, disclosing that the counsellor has a mental illness may be beneficial to the client. FG5 explained the following parameters of disclosure: "Generally, you're disclosing because you're facilitating some recovery process. It's not about you. It's about the person that you're helping. The benefit of your disclosure is for that person, not for you". Participant I-1, on the other hand, stated,

If I were a person being helped, I would really appreciate disclosure by the person helping me. But I think it is a very personal choice, something that would be agreed upon in the initial visit, the first time they meet. It would really rely a lot on the person helping, whatever they feel comfortable with—just keeping in mind that there is such a thing as disclosing too much.

From the foregoing, it can be seen that disclosure can have both positive and negative outcomes according to the participants, and therefore, disclosure needs to be defined from an organizational context. These outcomes are important to consider in developing a peer

counseling program. The same principles can be applied to the concept of boundaries in the role of the peer counselor.

Boundaries

Participants raised the issue of professional boundaries and explained these needed to be addressed prior to the development of a peer-led service such as peer counselling. Participant I-1 explained,

I think there are certain boundaries that probably shouldn't be crossed, like certain personal details, if it's involving someone else in that person's life, in the helper's life. There's a whole confidentiality issue on other people's part that should be left out. I feel that confidentiality is a huge issue that's easy to cross and that should always be kept in mind.

As well as boundaries relating to confidentiality, there can also be issues of being a friend in peer relationships to the client: "I think that as a counsellor there is absolutely no way you can be someone's friend. That's it. You cannot be a friend if you're a counsellor" (I-4). However, Participant I-1 disagreed and stated, "You can definitely grow friendships out of that client-helper relationship". In this participant's experience, friendships sometimes grow out of supporting someone else's needs.

Not all participants agreed with the idea of telling the client if the worker had a mental illness. The participants thought that boundaries need to be in place to protect the client.

Participant I-3 explained,

I think the boundary would be not to tell the client that they have a mental illness. They could later on if it was something that might help them understand the counsellor and make it more human, but there have to be boundaries in everything in what the client is told and what the client needs to hear.

Overall, boundaries set the tone for helping the client. The counsellor must not jeopardise the client's well-being. Participant I-1 suggested, "When it becomes about you, when it becomes about the helper and their life, then you've crossed a boundary, I feel. It should stay focused on the person that is being helped". Participant I-2 added that "boundaries are a huge thing that the workers, of course, learn. While they are protecting their own boundaries, they are respecting the boundaries of the clients".

Not only was it seen as important to understand the client's boundaries, but the counsellor would also have boundaries set by the organization and him/herself personally. Participant I-4 brought up an important point regarding professional practice and boundaries: "If a patient challenges those boundaries, gets aggressive with the psychiatrist, or tries to make the psychiatrist their friend, the psychiatrist is more than qualified as to where to draw the line". In this same regard, there was a current understanding expressed by one expert interviewee that peers who are paid to do support work have more risk and need more proper boundaries around the relationship. E1 explained,

Unless there is a lot of support and clarity around boundaries of that relationship, . . . peer support workers feel at risk if they don't . . . take people to emergency departments . . . or do those kinds of things that you would not find in peer support. The expectation was not that you would intervene, but with a paid peer support role, there is more expectation of intervening when there is a perception of risk.

According to the participants, boundaries would need to be established in regards to the job role of a peer counsellor. Participants questioned the parameters/boundaries within which a peer counsellor would work with clients. D1 stated, "It would really have to be spelled out and a model developed with what those boundaries are. Of course, the person going to be a peer counsellor would have to have it spelled out for them". Participant I-4 mentioned it would be

challenging to figure out what the boundaries in a peer counselling program would be. However

Participant I-1 stated,

I just want to disagree with the idea that it would be tricky to establish boundaries. I don't think it actually is tricky. I think it needs to be clear what the boundaries are. In order, I think for the success of that relationship, it has to be clear.

In the view of many participants, clarity of boundaries can help define the relationship and set parameters within which to council. While boundaries were considered important for safety and well-being, another issue arose that focused more on the human rights of people in recovery from mental illness. Social inclusion and access to choices of care were discussed by the participants at length as human rights issues that need to be considered.

Human rights

Human rights adherence means creating inclusive environments to allow people in recovery to contribute to society. Both of the expert interviewees agreed opportunities needed to be given across the spectrum of the health system to people in recovery from mental illness. However, they observed that there is still a sense of "us and them" when it comes to professionals and peers. E2 explained the recovery movement as: "Recovery meaning fostering hope, self-determination, choice, empowerment, helping persons to live beyond the limitations of whatever presenting mental health problems or illnesses there are". This enables clients to know their rights and responsibilities as healthcare clients. E2 also stated, "The goal is reintegration in society, recovery of personal self-esteem or self-identity, which is often robbed with the onset of illness". Human rights, dignity, and quality of life were expressed as the cornerstone of well-being for anyone accessing services. On this same topic area, E1 had realized, "I'm big on social

inclusion. If people aren't being moved to being part of their own community, being able to access all the same services everybody else is, I don't think we're doing people a favour . . . ”.

It was the view of the participants that integrating peers into health systems is a human rights issue and can transform those systems. However, as stated by Participant I-4, there are some barriers to having peer services integrated into the health system:

I think it's very threatening for professionals to have peer counsellors, peer support workers. For eons, the power has been with professionals. This is almost like shifting the power back to the clients. . . . One of the lessons of peer support workers and mental health teams is educating other professionals and other organizations.

According to Participant I-5, recovery and positive human rights-focused mindsets can promote integration, who understood that “many feel that you cannot transform the mental health system to become recovery-oriented unless you fully integrate it with peer support workers”. It was also observed that often times, increasing the quality of life for people with mental illness and systemic change comes from lobbying and petitioning the government. Participant I-5 stated, “I think it is helpful for people to begin thinking . . . about political action, how they can be politically active . . . Furthermore, I think people feel stigmatized, and then when they feel stigmatized, they feel that they don't deserve these things”. Stigma effects adoption of human rights mentalities and was identified as a huge barrier to accessing services and often marginalizes people. Participant I-5 explained:

You know that a lot of people have ended up living under bridges because they're not receiving appropriate care, and from a family perspective, I think people feared that if you strengthened the individual rights, it would accelerate that lack of support and responsibility for giving people quality of care.

It was stressed that the focus should be on raising the patients' quality of life and helping them and their family system get into recovery. Peer workers have insights that may be able to help this recovery process and advocate for the rights of the client, as expressed by E2:

They come simply as a peer, as part of a collaborative mental health team, to not only become an advocate for the client, but also to help the rest of the team, the caring team, how to make sense of what's happening with the client and not being just from a biomedical perspective or a psychodynamic perspective.

Participant I-5 likewise supported this notion and stated, "Everybody wants the same thing, which is that people live a good quality of life in the community. So the recovery is a way of starting to move towards that. Within that are elements of choice, informed decision making".

The idea that this participant was describing involved believing in the ability of clients to manage their illness and help them gain a good quality of life. Quality of life was an important factor in recovery:

When you talk about recovery and you talk about quality of life, I think, in a way, you're talking about two different things. . . . You could certainly talk about somebody's quality of life, regardless of how much recovery they might make, or to what degree that they have illness, . . . but recognizing that this illness can be severe for some individuals. (I-5)

Including people with mental illness in making decisions about their own care supports their rights and enables their responsibility to manage their illness:

For example, the Human Rights Commission in Ontario does a lot of work around identifying where people's rights are being violated, but rights are only useful if you can exercise some potency around them. . . . Even though people have rights, they don't exercise those rights, and partly it's because the tools and mechanisms aren't in place to allow them to do it. (E1)

Overall, E1 expressed the position that clients have human rights to proper mental care and towards being included in societal processes, and as can be seen from the foregoing, this concept was supported by other participants.

In summary, BCSSV has an opportunity to create an ethical basis for the development of a peer counselling program that considers use of disclosure, proper boundaries, and human rights issues. The global climate is moving toward peer involvement in a multifaceted way across health sectors. An inclusive and well-structured peer counselling program may break down the barriers of professionalism and peer work. The overarching philosophy of peer counselling and its definition as distinct from peer support is explored in the next theme. It also look at organizational readiness to move forward in developing a peer counselling program.

Theme 2: Clarity before action

The BCSSV needs to look at models of peer-led service that already exist to gain clarity before acting upon developing a peer counselling program. Thinking globally, Participant E1 advised, “Look at what’s being done and build on what’s happening in other jurisdictions. There is a lot of really interesting work that is happening in Australia, New Zealand and the United Kingdom”. E1 further explained what is happening regarding peer knowledge sharing forums and how we need to not reinvent the wheel:

I think we need to look at . . . what we are learning and build off that as opposed to starting again from ground zero. I think that one of the most important things that is happening with social media is that the world is now linked together, and consumers are linking with each other internationally. There are international forums where people are starting to come together to share new ideas and new approaches.

Although there are models of peer service that currently exist to learn from, participants raised issues that fit with an overarching philosophy of the peer counselling relationship needing proper definition. There was much debate over what this type of role would entail. Participants identified that much clarity is needed toward understanding what the scope of this program would be, who would facilitate it, and how it would be supported. This led to discussion of

organizational readiness to proceed with such a new program. There was much questioning of what dialogue and internal analysis would be needed from board members and other BCSSV stakeholders in order to proceed cautiously into an implementation phase. Included in that analysis would be dialogue amongst stakeholders on the definition and philosophy of peer counselling versus peer support as discussed below

Establishing philosophy and definition

Peer support and peer counselling are fundamentally different practices. However, the results of this research showed there needed to be a clear definition and distinction between what peer counselling is as opposed to peer support:

You get into a much deeper level of people's lives through counselling. I think what's important is that the counsellor is matched to the client and the client is aware of the difference between support and counselling, because they are fundamentally different.
(I-4)

Peer supporters do not generally utilize higher-level counselling skills, but instead use support and empathy to help their clients. Further to this idea, however, Participant E2 provided a definition of peer support work:

Generally, peer support workers are not referred to as . . . performing the role of a counsellor in terms of a therapist. . . . So the peer support worker, unlike the psychiatrist or psychiatric nurse, comes alongside of the patient, and because of mutually lived experience in a safe, welcoming way, the patient can discuss issues that they might not be comfortable discussing with the clinical team.

In considering a peer support versus a peer counselling program, Participant I-4, on the other hand, stated, "I suspect there's an element of counselling in peer support already. . . . I think it's hard to do peer support without actually talking about stuff".

Furthermore, some questions arose on the topic area of defining how much education a peer counsellor would need to work in the organization: “Is a peer counsellor someone who has a counselling certificate? They’re a registered counsellor? Are they a psychologist? Are they a psychiatrist?”. (FG1). Participant I-1 had some answers to these questions: “Part of what might be helpful would be for the peer counsellor or prospective peer counsellors to themselves take some generic counselling courses”. Overall, a peer counsellor would need to have some knowledge of counselling skills to be employed at BCSSV.

Defining the parameters of peer work in relation to the development of a peer counselling program is important. Participants questioned whether BCSSV should adapt peer work to create a professional peer role within the organization or if this would cause complications. Further to this, Participant E1 reflected that “the risk is that peer workers, particularly those embedded in the health care system, are at risk of migrating towards adopting more of the understanding of mental illness from that clinical level”. The point E1 was trying to make was that the peer relationships that are clinically defined create trouble around issues of dignity and choice for the client. This participant was also making reference to the lack of hierarchy in traditional peer services. E1 went on to make mention of intervention and crisis management issues in voluntary peer work: “The expectation was not that you would intervene, but with a paid peer support role, there is more expectation of intervening when there is a perception of risk”.

Currently, there are a variety of defined peer roles in place that relate to grass roots peer support, prompting E2 to define peer support as

working from a recovery philosophy and a rehabilitation model, but still maintaining the distinctive role of peer support, . . . you have a wide spectrum of peer support workers. You can just have a casual peer support person who works for a self-help organization,

answers phones . . . or you could have a peer support worker who does a little bit more specific consultation, . . . but then, you could have the more formalized peer support worker who is actually an employee in a semi-professional way hired by a hospital.

Traditionally these roles have been accepted in the spectrum of peer services practiced throughout mental health systems in the experience of participant E2. Terms like ‘peer support specialist’ and ‘peer supporter’ are widely used to describe the work (E2). Although peer support has a clear definition across a spectrum of care, clinical peer counselling has yet to be officially described, defined, and designed. This brings to the surface whether BCSSV is ready to proceed with these tasks. Determining the readiness of the organization to develop a peer counselling program was suggested by participants.

Determining readiness

A basic question that arose for participants was: Are we ready to take action in the development of a peer counselling program? Participants questioned that research is still needed to gain support from some of our funders and make the case for a peer counselling program. It was suggested that a partnership with professionals in the field or health authorities could strengthen client recovery. However, whether our community partners would support the development of a peer counselling program was an issue. An example of the thought process behind engaging community partners was stated by Participant I-4:

It’s not up to VIHA, first of all, unless they’re paying. It would be our service. It would be up to us to decide if we want to do it. For clients that are receiving a service from VIHA, and many of them will be, we need to get into discussions with VIHA about how we don’t duplicate what they’re doing.

This questioning process provided the dialogue that BCSSV would need to have with community partners to gain a viable action plan. Participants were concerned with garnering support from funders and community partners and what that process would look like. Participant I-4 stated,

We could be quite a valuable resource to VIHA if we can come up with a really well-researched, well-trained work group with really clear outcome measures, review criteria, supervision input. It's really cutting-edge. Safety is really huge. Then we're in a strong position to say, "We might be able to help you, and maybe other organizations in the area".

In order to proceed, BCSSV would need to create a case for a peer counselling program that funders could trust and which would change their attitude towards peer work. One expert interviewee expressed the concept that in order to gain the trust and support of professionals in the mental health field, you need to change people's attitudes on recovery processes and the people experiencing illness: "You want to change professionals' attitudes" (E1). In understanding how to change people's attitudes, "it's not enough just to poke people in the eye. That just makes people angry. . . . You have to give people a sense of what gets in the way of people recovering and what helps people recover" (E1). E1 also explained a way to change systemic health care attitudes: "If you want to change people's attitude, you have to create opportunities for disclosure, discussion that dissuades people of the belief that somehow, people with mental illness are dangerous, impulsive, erratic, or incompetent". Once perceptions are shifted, trust can be built.

Another issue of organizational readiness comes from the development of a strategic plan that will inform future directions for the organization. According to Participant I-4, BCSSV is currently planning a strategic review to have a look at the future direction for the organization:

We need people's input into how best to do the strategic review, for sure. One of the things the strategic review can ask is: "Should we be providing a counselling service?" We can ask that question. We need to get evidence for this. . . . Where's the evidence that these things work? (I-4)

Although the strategic review will set a course of action for future planning, some cautionary responses came from a participant regarding changing the nature of services at BCSSV:

I think the board of BCSS has to be very aware that this is changing what we do. This is bringing BCSS up to a level where . . . we are saying that we are actually providing treatment. . . . Do we have the systems in place and the people in place as staff to support that kind of a situation? (FG2)

Strategic planning can create opportunity to explore what is working in other programs that is transferable to peer counselling. It could also support the establishment of internal guidelines for peer work that crosses into a treatment structure. BCSSV would need to set parameters on the type of treatment we provide, if we provide it at all. Currently, the family counselling program is the only internal example of programming that we can draw from to answer these questions. In response to participant concerns about treatment versus support, FG2 questioned how our current family counselling program would fit into the development of new programming in the area of peer counselling:

When we have a family counsellor, is our family counsellor providing treatment, or is she providing support? Do we differentiate between the two there, and if we don't, we would need to look at that relationship in comparison to what it is that is being put forward here as a possible direction for BCSS to go.

Out of the discussion of organizational readiness, participants discovered the need for more research to answer their questions about treatment, strategic planning, and funder support. Participant I-5 believed that in order to find out what currently exists that is working in peer services, "I think you do a little research. You take a look at those peer support programs that are

out there, and you just pull in what you think would be helpful for this program”. According to Participant I-3, internal research conducted on the current peer program could offer some insight into the development of a peer counselling program and to discover their current training needs:

We have to look at the overall program and how successful it has been taught to the peer support workers and see what they think they need to make their clients more comfortable and to improve their skills. . . . The peer support workers know what they need and what they don't need.

Participants agreed that further challenges to implementing a peer counselling program exist. To alleviate the concerns of readiness Participant I-4 commented, “There are always going to be challenges out there for the peer support counsellor or peer support worker. There is always going to be someone who is going to come in and not know what they need”. Funding was one of those challenges for participants. An issue of viability arose out of whether funding was available for this type of program. Participant I-2 explained their fears about viability:

The other thing that I see happening all around me is we could get funding to run this program, perhaps, for a year or two, and then not be able to sustain that program. We could get the program up and going and then suddenly lose funding and have to close it down.

Readiness may rely heavily on funding support. Funding for further research may not be available to mental health organizations. Exploring the topics necessary for the implementation of a peer counselling program may have to come from independent established sources. E1 found that funding may be scarce to do research projects, having stated,

The equity and parity thing is manifest all across the system, including being able to get resource to do this research. So there is a completely unlevel playing field in terms of accessing public research dollars to begin to create a stronger evidence base behind peer support.

There may be other options for funding more research that exists in the community. In regards to a planning phase that may be less dependent of funding sources, Participant I-5 explained,

I think you could get a lot of that from the counselling community within Victoria. . . . Then, of course, BCSS would have their own experience. . . . The only stipulation that we would have that would be different is that we want that individual to be a peer in the sense that they've actually had the lived experience.

In summary, the participants had valid and justifiable concerns regarding community partner support, the need for strategic planning, treatment versus support issues, and funding. Participants want to make sure the organization is ready to develop a peer counselling program and the structure to support it.

Theme three: The need for structure

On a practical level, the structural requirements and innovative status of a peer counselling program were a large issue for the participants. The participants were wanting to set up a system or approach to develop this program that adhered to general standards of practice in related fields. There was practical discussion regarding professional program support, pilot testing, innovative measures, and staffing requirements. Overall, participants wanted to explore the structure of a peer counselling program that would set BCSSV up for success, and be properly aligned with counselling and peer standards and funder requirements. Some of this questioning was stated by Participant I-5:

What are the measures in place that are determining how people are benefiting from it? . . . What's the feedback from the peers . . . from families and professionals? They hear things as well. It's helpful for them to bring that feedback back so that you have a kind of loop that goes back, and the program is always open and responding to the feedback and improving.

The need for structure and innovation of programming that establishes feedback loops and stakeholder commentary was expressed strongly amongst participants. In order to create these avenues of critical evaluation, participants stressed that BCSSV needs to look at both internal and external programs that have been innovatively designed and draw from their design. The section below captures some participants' observations on how BCSSV has innovated in the past. Participants' observations are also captured about other programs that have been created that could be deemed innovations in peer services.

Innovative models

Participants were not aware of any formal peer counselling program in mental health services. However, they spoke of being aware of other mental health programs that engage peers. Participant I-4 described an example of peer services: "There's Umbrella, which deals with people with addictions. I think many of the people working in Umbrella have been through addiction themselves". "Assertive Community Treatment" teams was another innovative approach to employing peers described by E2, who stressed that this approach still needed proper guidelines, "There are some PACT teams that do have peer support workers. . . . It depends on the particular philosophy, how well that PACT team understands recovery, how recovery-oriented they are" (E2). Other innovations provide new tools that support client recovery, such as rehabilitation plans, which are designed by peers:

The peer support movement has actually internationally adopted a number of new modalities of how to help people move towards recovery from a peer perspective through the use of things like the RAPD [Rehab Action Plan Development] from creating recovery centres, of helping people acquire new knowledge and skills, and bringing experts in as a resource to consumers so that they can master and manage their illness and their lives for better outcomes. (E2)

Not only are there external community innovations that BCSSV could draw from, but the organization itself has also approached peer service delivery from an innovative and clever perspective. Participant I-2 explained that in the past, BCSSV was a very innovative organization: “The board in the 80s and 90s started a consumer representative position which was innovative. . . . It was something, but that was something the board was open to, probably almost from the beginning”. Furthermore, Participant I-2 explained the innovation of changing peer supporter status in our organization from volunteerism to a paid staff role: “It was an extremely clever idea to make them staff. Making them staff changes the way they’re viewed out there, when they’re working out there in the community”.

According to participants, innovation is supported by BCSSV, and yet, careful consideration of the training needs to sustain those innovations is also necessary. Participants’ ideas on how much training a peer counsellor would need to sustain this kind of program are explained in the next section. Training current peer supporters in higher levels of skills or requiring a peer counsellor to have a degree were some of the training ideas discussed.

Training

Participants questioned how the current peer support program could be enhanced to take on a counselling approach, thus bridging the divide between peer support and peer counselling. It was mentioned that BCSSV could expand the current peer program by training current workers in higher-level skills used in counselling. For example, Participant I-5 explained that “it would be very helpful for the peer support worker to learn as much as possible, as much as they could, about how the system operates and about illnesses and about individual responses to medication”. Participant I-3 agreed, stating, “I think the peer support is great, but I think they

need to go one step further and learn higher counselling skills to maybe sit down with a professional and learn their techniques”.

Participants in this research project explained that training structures needed to be understood and developed appropriately before proceeding to develop a peer counselling program. This was viewed as especially important if a peer worker gains a professional status. Participant E2 brought up some concerns about the structure of peer roles and accountability at a professional level, stating, “It’s at that level that there’s the importance for there to be appropriate training and credentialing and accreditation”. E2 further highlighted an organization developed by a peer services expert to support these issues:

The acronym is PSAC for Peer Support Accreditation and Certification. . . . Its goal will be to standardize training of peer support workers leading to credentialing as a peer support worker as well as set standards for the accreditation of organizations that want to utilize and employ peer support workers in a more formal fashion.

More research, guidelines, and training support like what PSAC is implementing are needed in the area of peer professionalism. However, there are national guidelines for peer work being released soon. According to E2, the MHCC will release a set of peer employment guidelines:

Primarily, what will be released very shortly will be two sets of guidelines. There will be guidelines for organizations that wish to employ peer support workers. That employment setting could be in a hospital, a psychiatric unit, mental health centre.

Participants suggested that it may be useful to seek out other training resources to develop a proper structure. According to participant E1, reinventing peer structures may not be needed. To this participant, BCSSV could reach out to other social movement groups to learn about the current structures of peer work: “That’s where looking at other movements. . . . The whole gay movement thing. There’s a lot that we can learn from them about how they mobilized

community and used rights and used their economic power to make changes”. Although in agreement that online resources to support training needs in peer programs would be useful in understanding peer practices, Participant E1 had concerns about professionalising peer support. E1 was also concerned about moving beyond the essence of the peer movement, expressing this concern as follows:

Personally, I'm uncomfortable with the idea of teaching modalities that are clinical to peer support workers because you are neither fish nor fowl. You are neither truly a peer support person who is talking on an equal level. . . . Every time you do that, every time you introduce another level of credentialing and skill, you change the power differential between you and consumers.

Not all participants agreed on how much training a peer counsellor should have. That said, Participant I-1 agreed with the above statement completely, explaining,

I think too much training; in this case, with a peer support kind of situation would be a bit detrimental to the relationship because you get into that mind space, I think, where it's analyzing what the person is saying instead of relating.

However, other participants explored the positive potential of training peers as in counselling skills. This included conversations on what type of training and which credentials would be needed to properly structure the program. Participant I-4 explained his/her views on training as “We need to really think carefully about training. . . . Then we need to start thinking about which model of counselling is this organization going to support. Is it cognitive behaviour therapy? Is it DBT? . . . Is it Rogerian personal counselling?”. Participant I-5 added a list of training ideas to this discussion by stating that a peer counselor would need to be well-versed in a variety of mental health topics:

They could improve it by helping them to manage the symptoms of their illness, helping them to find housing, helping them to learn how you get along with family. . . . They need to be well-versed in symptoms of illness, of psychosis and schizophrenia. They need

to know what the treatments are. They need to know something about the medications. They need to know something about counselling.

Participant I-2 also saw value in the training of peers at a higher level of skill, but questioned what those skills would be:

When we get into the specific skills that would go beyond just generic skills like reflective listening, ethics, empathy . . . Cognitive Behavioural Therapy is a big one. Possibly Dialectical Behavioural Therapy, if they wanted to specialize in helping people with personality disorders, people with those diagnoses. Also, they'd need some basic training in what the basic symptoms and treatments are for the major mental illnesses — medications.

In support of these training ideals stated by Participant I-2, Participant I-5 commented that a peer counsellor would also need to know what other services are available in the community: “They need to know the services in the community. . . . They need to know about what role exercise plays in mental well-being and neuroplasticity”.

The idea of training peers in clinical skills did not sit well with participant E1, who expressed valuable concerns:

The whole concept of making peer support a profession. . . . Before, it was a mutually engaged pursuit of people of equal status coming together to share support and resources amongst each other, and then through that learn from each other and become empowered. It's only recently that the idea of paying people to provide that service had been introduced, and I think it requires unpacking, because it does change the voluntary nature of the relationship.

Although peers have value in the mental health systems, Participant E1 continued to state further concerns around peer services and how workers are trained:

The risk is that peer support workers, particularly those who are embedded in the health care system, are at risk of migrating towards adopting more of the understanding of mental illness from that clinical level, sort of being absorbed into that paradigm, and so issues around choice and dignity of risk become more troublesome in that peer relationship

Overall, there were concerns from participants about the nature of peer counselling training. Participants believed that the training component of a peer counsellor role needed to be researched, designed, and established with careful thought and support from the stakeholders of the organization. Not only were types of training and national standards in training important to the participants, but so also was the development of a supervision model to oversee the work. This is discussed below.

Supervision

The topic area of peer counsellor supervision arose, but was debated. Whether a higher level of supervision would be needed to support a peer counselling program garnered differing responses. FG3 stated,

We're not just talking counsellors. Those counsellors are going to need supervision. Who will be those supervisors? Are they going to be voluntary, or are they going to need to be paid? Another added cost. It would be unthinkable to set this up without support for the counsellors. They have to have supervision.

In disagreement with FG3 on the issue of extra supervision for the peer counsellor, FG1 stated, "But if we were to compare a counsellor, say, at the university, or a therapist working at VIHA, they don't get special preference because they're above another employee at VIHA. They would get their employee assistance program paid for". Supervision is an issue in the development of a peer counselling program. It is unclear to participants if the supervisor would come from within the organization or from an external source. FG3 continued the debate on supervisory needs of the counsellor by stating,

Counselling is a specialist field. Not everybody can support that person. Right now, I'm not sure who in the organization would be qualified to do it. . . . I'm thinking they would need to look outside of the organization for their support, which they may already have.

but whether they would be prepared to pay for themselves or whether they'd be expecting their employer to pay it

Whether supervision was needed at all created a debate amongst participants. A differing view on the supervision of a peer counsellor was commented on by participant FG1: "If they came to you and they're a professional, they don't need supervision".

Another area of interest brought up by a participant regarding proper supervision within a peer counselling program involved connecting to the clients' support network. Participant I-5 concluded that this type of program may need collaborative efforts between the person with mental illness, the case manager, the psychiatrist, and the peer counsellor. In collaborating with the client's professional support network, supervision requirements could be enhanced.

Participant I-5 commented, "I also thought there should be a high degree of trust and collaboration between client, family and professionals". Dialogue between the people supporting the client creates a network of care, with each supporter checking in with each other. In this regard, Participant I-5 questioned,

If a client has a peer support worker here, and . . . a case manager in the community, is there dialogue between the case manager, the peer support worker, the psychiatrist, and the family? How is all of that brought to bear so that that client is actually being served the best way we know how? . . . Do you have a case conference? How do you keep records of what the supports are of this client?

Overall, participants viewed that supervision can be acquired in multiple ways that support the clients' well-being. However, finding and recruiting the right peer counsellor willing to work with a client's team was an issue.

Recruitment

Keeping in mind current hiring practice at BCSSV, the participants described how and whom they would hire as a peer counsellor: “However you go about posting your positions somewhere, whether it’s in the newspaper or whether it’s online. . . . would be a good process”

(I-5). Participant I-2 understood that:

People who are already peer workers would submit to an interview process by people at the office who are qualified, or you could bring in other people outside the office who are qualified. . . . Those peer workers who wouldn’t be accepted into the training for peer counselling would themselves need to be debriefed for as long as necessary and be helped: given help or counselling or informal counselling.

Participant I-5 also explained that the hire would need to answer the following question appropriately: “How do I look after my own wellbeing?” While asking the right questions was important to participants, I-1 advised that the first step would

be recruiting potential peer supporters. That would probably be starting with the people that are coming to volunteer for BCSS Victoria already and then just building relationships with them and reaching out further, because I think the peer supporters should be people who are already invested in the Schizophrenia Society.

I-2 proposed an idea about recruitment structure: “I think we should give pride of place to the current peer support workers. They already have interaction with the clients that are currently on our roster. . . . If they showed signs of being able to be effective peer counsellors”.

However, FG3 discussed the importance of setting up parameters of when a peer counsellor could be hired after hospitalization or stabilization. FG3 questioned recruitment parameters:

How do we, as an organization, recruit a peer counsellor? Are we saying that someone could be an active client in the mental health centre and be a peer counsellor? Could you end up with a situation where the client shares the same case manager or has been in the

same day hospital group? We have to really think carefully about who we recruit and what stage of their life they are at.

In order to recruit a peer counsellor, the BCSSV would need to decide at what level of recovery a peer counsellor would need to be. In regards to this point Participant I-4 explained, “I think what’s really important is that the peer worker is in a good place themselves and has insights into where they’re at and, in particular, how stress affects them and how hearing other people’s stories affects them”.

In summary, participants viewed that the hiring process for a peer counsellor needs much consideration. Proper adherence to standards in peer work could support the development of this type of program. Although a clear structure was viewed by participants as helpful, they also shared both strengths and risks to the development of a peer counselling programs, which are discussed in the next section.

Theme four: The ‘two sides of the coin’ of peer counselling

There are both strengths and liabilities to the introduction of any peer-driven program. Participants explored both their fears of liability and their positive viewpoints of how peer programs can support client recovery. The ‘two sides of the coin’ could support or prevent the development of a successful peer counselling program. Some of the positive and negative issues discussed in this theme include: power differential, the BCSSV reputation, qualifications of the counsellor to prevent issues, and equality of relationship in peer services. Overall, participants were cautious to explore potential liability and eager to utilize the strengths that already exist in peer programming.

Liabilities

Participants identified that there are risks to proceeding to develop a peer counselling program. Liability issues were at the forefront of this discussion. The topic of public image in regards to potential litigation was an issue for participant FG3:

If a client was unhappy with the counsellor they received, that might reflect on the organization as a whole. This organization currently has a very good, exemplary almost, reputation in the city as a recovery-based mental health organization, . . . but litigation is a risk if someone is not happy. There's the possibility that they may sue.

More litigation and insurance issues were also raised by participants as part of the dialogue. As Participant I-4 explained, "There's insurance, for a start. If somebody did commit suicide after seeing one of our counsellors, the family may sue BCSS. 'Your counsellors weren't qualified enough. Your counsellors weren't supervised well enough.'" Participant FG2 further explained in regards to liability insurance:

I would expect our liability insurance would have to be increased quite a bit as we are doing more and more treatment. . . . We would have to have insurance that would cover difficulties that could happen if people were in crisis.

In agreement with the other participants, FG4 supported cautiously, in stating,

Some real, practical difficulties and problems that could arise: litigation, the financial shape of BCSS, and the need for liability insurance. . . . I can see potential problems, too, of the peer counsellor going into crisis and being unable to function in the midst of a professional relationship with a peer being helped.

In support of the above risks and in thinking of the future, Participant FG2 added:

The organization itself at the moment is on kind of shaky financial ground. I think there is a risk in expanding the amount of work that we are trying to do. This program would have to be self-sustaining. We'd have to raise the money.

There was also some disagreement about and risks associated with safety and counsellor qualifications in the development of a peer counselling program, which was expressed by E2 as follows:

The risk is that people who work as peer support workers are not qualified, or who either are not well enough to be doing what they're doing or . . . don't have the competencies, don't understand the values . . . not knowing how to effectively honour their role without hijacking it or straitjacketing them or providing safe environments

In this expert participant's view, the idea is to create safety for peer employees and make sure people are qualified to do the work they are in the organization to do. As explained by E2, liability can come from not supporting peer workers enough in their roles as employees. The workforce needs standards of practice that create supported and accommodated employment for peers that is safe for people with mental illness working in the organization:

The Mental Health Commission of Canada released its psychological safety standards in the workplace, so you apply those psychological safety standards in the workplace for all your employees, including peer support workers, whether that's mentors or whether that's having special work accommodations, accommodating the particular worker to their particular needs. (E2)

In support of the above statement, Participant I-2 voiced some concerns: "Do we have the systems in place and the people in place as staff to support that kind of a situation? It's the liability. It's a whole lot of things that worry me a bit". Some organizations that work with peers have accountability groups to support peer work, as explained by E2:

Then also peer support workers themselves could have some sort of mutual accountability group. So, let's say within the city of Winnipeg, you could have a peer support workers' association in which you periodically get together in terms of meeting to not only talk about improvement of skills, but to [also] address emotional issues that they're experiencing, what we call transference.

There were, however, some more basic risks that participants explored such as confidentiality. “These are the risks and challenges or a combination of peer work and professional practice for me. That confidentiality thing, the more I think about it, the more huge that is, actually” (I-3). Participant I-5 disagreed that confidentiality and conflict of interest would be a large issue, stating,

A couple of red flags went up for me when some things were being mentioned in the area of confidentiality and conflict of interest coming up. Having been very ill myself . . . and encountering past nurses, counsellors, case managers, and becoming colleagues with them . . . networking with them has been bizarre, but it is very possible.

Although the crossover from being in recovery to being a professional can create a sense of lack of safety for people with mental illness, it was viewed as possible. Also, conflict of interest in this crossover can create liability, and Participant I-3 questioned:

What if the peer counsellor . . . had been on a patient unit with the client? How do they negotiate history? . . . It happens, because they’re employed, and they’re seeing clients that they have been on an inpatient unit with. That hasn’t got in the way of their performing their role, but it could.

The liability was seen to arise out of the peer having been ill themselves and then being in a power over role with the client. If the counsellor and client had been in hospital together, there could be issues of equality that could lead to liability. Another liability issue raised by participant I 5 that related to the peer relationship was expressed as follows:

I think there is a contingent of people that have difficulties maintaining their mental well-being. . . . They may have a very strong bias against the medical profession or against psychiatry as a discipline, and so they might bias the person that they’re counselling, so that could be a risk.

Lastly, according to the participants, in the peer counselling relationship, the counsellor has the ability to hinder or support the client, which could leave the organization liable for any risks that arise:

I think a risk would be that the person giving the support might be expecting too much of the client. What I mean by that is the person giving the peer support might assume that where they're coming from—their vocabulary, their experiences—will automatically be picked up on by the client, so the peer worker might be expecting that the client knows where they're coming from. (I-2)

This relates to a statement made by Participant I-1 in regards to the counsellor having sensitivity skills: “What I imagine would be a risk might be a lack of sensitivity or understanding on the part of the peer supporter or peer counsellor”. In a similar fashion, Participant I-1 continued in stating, “I've learned a lot about how it's very easy to not acknowledge someone properly or just not be as mindful as you could be about where they're at”. In this regard, it was acknowledged that not knowing how to control client behaviours was a risk:

One of the risks I see coming up is the person was in a counselling session or if they were out in the community with their peer support worker and . . . they decide to have some sort of violent act or decides to pick a fight with someone. It may be to the point that the worker doesn't have enough people there to help him or her. (I-3)

Overall, participants' concerns with liability issues and litigation were thoroughly discussed. The risks involved in peer counselling included potential of damage to the organization's reputation, lack of counsellor skills, and law suits and confidentiality issues. The participants agreed that there needs to be careful consideration of liability in the development of a peer counselling program. In the next subtopic, I explore the 'other side of the coin' being the strengths of a peer work and peer counselling.

Strengths

Participants also articulated that peer-led services have many strengths that help clients work towards recovery. Areas explored included the strengths of the current peer program and peer-led services in general in the mental health system. According to participants, the benefits of a peer counselling program are that:

It adds over and above what we already have in peer support . . . a peer counsellor would have more qualifications in certain respects than peer support due to extra training. That might make someone going to peer counselling . . . give them confidence . . . that they're in the presence of someone who has that extra training, who could possibly have an extra take in understanding where they're coming from. (D1)

Participant FG2 also agreed that peer counselling would bring a new level of skill to the peer relationship, but had cautions to add as well:

It adds a layer of expertise onto the kind of program we have at the moment of peer support. In some ways, maybe it's a bit of a safety valve. There's always the possibility that the peer supporters will come across a situation that they don't know how to handle. Then they have got another person to kind of refer that peer to who has a better way or [is] more knowledge about how to handle it.

Participant FG1 also agreed that peer counselling added a positive potential to the mental health community, by offering another choice in service for clients. FG1 stated,

You have your peer support worker. You have your peer counsellor. Then you have your psychologists in the community. You have your psychiatrists that you see. You have these levels and different services, so you have more choice. Maybe with these different services, you can then have a better fit for what the person is looking for and what's out there that can come together.

Giving clients choices empowers them to be in recovery, and this issue of client empowerment in the recovery process was a thread in the research data. Participant FG2 added:

“Some people in recovery would feel more comfortable coming from someone they also know

has been through some similar experiences”. FG1 also agreed that empowerment is important to recovery, stating,

It’s empowering for both, for the peer counsellor . . . and for the person going and seeking help or advice or support. . . . The power imbalance that currently is so prominent between the client-psychiatrist relationship . . . is really intense. . . . There is a greater level of comfort when you’re talking to someone who has been where you’ve been.

Participant I-5 agreed with the power of personal life knowledge and how sharing this information can help a client into recovery:

The biggest strength is the fact that the peer support worker has been there. They have the lived experience of having to deal with what can be a very, very difficult situation. . . . I would hope that the peer support worker is modelling . . . that they were able to transcend . . . that difficult illness that may reoccur, and that in doing that, they pass on that kind of hope to the individual that they’re counselling.

Participants stressed that having been a patient of mental health services builds a sense of expertise in the person experiencing mental illness. Coming through the suffering that illness entails into a state of recovery presented for them an opportunity to share that knowledge with others. Participant I-4 further described the power of life knowledge of mental health systems:

For many clients, . . . somebody who’s had that lived experience is going to be able to help the client in a different way to somebody without that experience. . . . In many ways, I think a peer worker is the first person that really demonstrates true understanding of what that client is going through.

Sharing lived knowledge of having mental illness creates a sense of equality, and the peer relationship is about equality and levelling the power imbalances found in professional work according to participants. Participant I-1 stated,

I think that if you’re going to share personal experiences, it does promote a lot of equality. . . . I think one of the major things that creates a power imbalance is the whole “You’re going to tell me about your whole life and all your issues and all these personal struggles,” and I’m going to sit here and analyze you. I have a certain amount of power over you.

Participants described this as empowerment and also about breaking down the stigma associated with having a mental illness. As explained by Participant I-3,

There is stigma around any mental illness. . . . People don't want the general public to really know what's going on with them, but they need to know that it's safe out there and that if something should happen, the counsellor knows what to do to get that person out of that area so that they are safe and they feel more comfortable. Getting that person out also will help with that stigma and getting them more used to the general public.

Participants spoke of reducing stigma as being important for recovery and as helping people out of their pain.

Furthermore, peer workers were viewed as having an ability to help clients feel heard and understood. Participant I-1 explained the strengths of peer work as opposed to clinical work:

There are a lot of clinical aspects to that, and it's not very human. It's almost robotic on their end. I think, from a peer supporter's role, they already have that experience, and they may be disclosing with you. They have a really strong tie to what you're feeling, and that's known, and it's apparent, and I think it's very valuable.

Not only did participants view that peer workers bring insight of mental illness to the counselling relationship, they bring knowledge and wisdom as well. Participant I-2 explained some of the value in the information a peer worker has of the mental health system that could help the client. The worker can say, "Okay, this is what's out here, this is what's there" (I-2). A peer counselling program

would be an extremely good assistance to someone coming say, straight out of hospital, and we're assuming no family support. . . . If we're taking a different kind of client who, say, had family support, who had a place to live with their family while they were recovering. (I-2)

Finally, on a simple level regarding peer work, Participant I-3 stated, "The strengths are that everyone is very friendly and knows what they're doing". Participant I-1 agreed, stating, "From what I gather, for people engaging on a peer basis, it's a lot more encouraging, a lot more

positive”. The positivity that peer workers bring makes the relationship with the client more encouraging and friendly. Overall, participants saw many strengths in peer relationships that enhanced the recovery for the client, which included breaking down stigma and empowering clients in their own wellness management. Further to this point, the current strengths of peer support could promote a case for a peer counselling program and fill a gap in the current mental health system. Participant FG3 explained that “one of the benefits might be that it could potentially raise our profile within the city and within the mental health community and might meet an unmet need that is out there”.

In summary, peer programs were viewed as having many strengths that could support the development of a peer counselling program. These strengths included empathy, stigma reduction, and inspiring hope through sharing insights into recovery. Participants found that these strengths are an asset to the mental health community.

Summary of findings

The thematic analyses presented in this chapter explored the issues and ideas of the participants in regards to the development of a peer counselling program. There were many themes and sub-themes that arose out of the data. Ethics, participants explored peer employment, disclosure, boundaries, and the human rights issues that currently exist as peers enter the mental health workforce. For example, the participants questioned whether disclosure would create positive or negative outcomes in supporting client well-being. It was understood that proper boundaries need to be put in place to protect both the client and the counsellor from high-risk situations.

The above thematic analyses explored the issues and ideas of the participants in regards to the development of a peer counselling program. There were many themes and sub-themes that arose out of the data. In the section one ethics participants explored peer employment, disclosure, boundaries and the human rights issues that currently exist as peers enter the mental health workforce. For example, the participants questioned whether disclosure would create positive or negative outcomes in supporting client well being. It was understood that proper boundaries need to be put in place to protect both the client and the counsellor from high risk situations. In theme two participants explained that there needs to be a distinction developed between peer support and peer counselling; a clear definition of both programs needed to be established. There was also dialogue on the organizations readiness to support the development of a peer counselling program or engage in more research on the topic area. The theme three topic explored that in order to be more prepared for an implementation phase the participants wanted to understand the current innovation that a peer counselling program would bring. They wanted to understand how it differed from other programs currently existing in the mental health community. Issues of training, supervision and recruitment were also explored in theme three, and ideas were stated to fully understand the needs of the organization and what resources would be available to help in these areas. Theme four explored the potential liabilities and strengths of a peer counselling program. Participants stated their fears for the organization involving law suits and on the 'other side of the coin' how beneficial a peer counselling program would be. Strengths included the equality of relationship between peers and the level of understanding and empathy peers have for each other. The information provided by the participants will inform the conclusions drawn by me as stated in the next section.

Conclusions

This research was conducted to inform BCSSV on the issues regarding the development of a peer counselling program. Through the research process and analysis of the findings from the interviews and a focus group, four conclusions were drawn that were also supported by literature. The goal of the conclusions is to share my understanding and insights gained from the research data. In explanation of the conclusions, Stringer (2007) stated, “Its purpose is to show clearly how stakeholder perspectives illuminate the issue investigated and to suggest changes in organizational or programmatic practices implied by the research” (p. 183). The following conclusions relate to the participants’ exploration of topics such as ethics, organizational readiness and change management processes, the complexity of liability, and the potential to be pioneers of innovation through garnering community support.

Conclusion one: A strong ethical base is the foundation upon which any peer programming must rest.

The establishment of an ethical foundation for the development of a peer counselling program is an important part of taking action in this area of programming. Ethics forms the continued safety net and sense of trust upon which clients and counsellors can come together in the helping relationship. In regards to trust in relationships, people “want to know that person is truthful, ethical and principled” (Kouzes & Posner, 2007, p. 32). BCSSV needs to be aware that “as you serve the values of freedom, justice, equality, caring, and dignity, you can constantly renew the foundations of democracy” (p. 346). These are the basic building blocks of ethical treatment and counsellor behaviour. The ethical structure that BCSSV will develop for a counselling program will rely on a set of expectations that the counsellor will adhere to around

boundaries, disclosure, and the human rights of the client. Wheatley (2006) explained that “the potent force that shapes behaviour in these organizations and in all natural systems is the combination of simply expressed expectations of purpose, intent, and values, and the freedom for responsible individuals to make sense of these in their own way” (p. 129). As the BCSSV stakeholders dialogue about these types of expectations, “a pattern of ethical behaviour emerges” (p. 129).

The findings of this inquiry demonstrated that the relationship between client and counsellor can be a challenging one for many ethically sensitive reasons. These reasons included past co-hospitalization, friendship issues, power struggles versus equality issues, and level of wellness differences between both parties. The peer counsellor may have known the client from past friendships or recovery programs where they were both clients, which could complicate the relationship. Glesne (2011) stated for example, “Whether friendship or friendliness is the case, ethical dilemmas can result. You may gain access to intimate information given to you in the context of friendship” (p. 171). Information shared between counsellor and client would be subject to issues of trust and potential boundary violations. The relationship “carries with it responsibilities and considerations, including reflexivity on the nature and influence of the relationship, analysis of the role of power in the relationship, and attunement to relational ethics” (p. 171). Power of influence, personal power, and power over the client are important issues to the development of a peer counselling program. Although ethics is a key consideration in creating well-structured peer counselling services, the organization must be ready to take action with a strong change management plan. This is discussed in conclusion two.

Conclusion two: The philosophies behind peer counselling need to keep in mind

organizational readiness and change management processes.

The BCSSV may or may not be ready to proceed with the development of a peer counselling program. Change management processes can support progress in this area. The currently established emotional climate at BCSSV is one of questioning what change measures are needed to develop a viable peer counselling program. Goleman, Boyatzis, and McKee (2002) explained that “change begins when emotionally intelligent leaders actively question the emotional reality and cultural norms underlying the group’s daily activities and behaviour” (p. 195). This is a practical first step to creating dynamic change and promotes establishing organizational improvements. Kouzes and Posner (2007) stated, “The work of leaders is change. And all change requires that leaders actively seek ways to make things better, to grow, innovate, and improve” (p. 164). Developing a peer counselling program is an opportunity for change that could position BCSSV as an innovative leader in the mental health community.

Establishing a sense of meaning and purpose for peer work is important in today’s mental health care climate, as it aligns with human rights and inclusion principles. The voice of people in recovery is meaningful to BCSSV and to experts in the mental health field. According to Wheatley (2006), “We change only if we decide that the change is meaningful to who we are” (p. 148). Whether developing a peer counselling program is supporting our future directives, our mandate, or our public image is also important to discuss. “People need to explore an issue sufficiently to *decide whether new meaning is available and desirable*” (p. 148). A peer counselling program could add new meaning to the organization in the areas of service delivery and the advancement of peer-led care. However, the reality that BCSSV faced is that there are many steps to acknowledge before proceeding to develop a peer counselling program, and before

BCSSV is ready to take action. A proper structure for a peer counselling program that aligns with established change strategies could move the organization into being ready to create a successful program. “Some standard practices, policies and procedures are critical to productivity and quality care” (Kouzes & Posner, 2007, p. 185). Creating a vision for action, through evaluating current practices, understating the organization’s current reality, and initiating a structural design that supports peer counselling is important. As explained by Goleman, Boyatzis and Deal (2002), “Once the cultural reality has been uncovered and explored, the next stage . . . requires defining an ideal vision for the organization that is in synch with individuals’ hopes and dreams for themselves” (p. 202). A proper vision can dissolve readiness issues through providing a solid direction in which to proceed. Readiness issues are not just about meaning, purpose, and structure; it also involves fears of liability as discussed in conclusion three.

Conclusions three: On a practical level systems need to be in place to develop a peer counselling program that consider the complexity of potential liability.

Liability issues exist across the mental health system, not just in peer work. It is a complex reality in the development of a peer counselling program. As this is a new area of peer work, there are many areas of potential risk, including: power imbalances and equality of relationships, confidentiality, insurance issues, human rights issues, safety considerations, the reputation of the agency, the ability to find funding, and the training and supervision of counsellors. Systems need to be put in place that build program competence to prevent liability issues for both clients and counsellors and the organization itself. “Developing competence and building confidence are essential to delivering on the organization’s promises and maintaining

the credibility of leaders and team members alike” (Kouzes & Posner, 2007, p. 260).

Competence in the arena of program delivery can enable a safety net around liability issues.

However, liability may not be such a difficult issue that results in avoiding program development. Wheatley (2006) stated, “Change always involves a dark night when everything falls apart, Yet if this period of dissolution is used to create new meaning, then chaos ends and new order emerges” (p. 170). It can be exhausting to not trust the process. “The source of our fatigue is that we don’t have the organizational structures or the leadership that can respond well to these emergencies” (p. 171). Creating structures, such as role descriptions, program definitions, and policies and procedures, can create the safety net that mitigates liability issues.

Exploration of the structures that are already in place can enlighten the change process. This is the same for researching unknown processes that can be found externally to the organization. Senge (2006) stated, “Structures of which we are unaware hold us prisoner. Once we can see them, they no longer have the same hold on us” (p. 149). Being aware of what the unknown issues, potential conflicts, and missing structures are could assist in mitigating liability. Then looking outside the organization for structural support and resources may create an environment of success for any innovation. BCSSV does not have to be fearful or isolated in the development of a peer counselling program as the next section discusses.

Conclusions four: The BCSSV is not alone in being an innovative organization and can draw upon other community resources in the mental health system if it were to develop a peer counselling program.

Community engagement and the utilization of already established resources could help BCSSV be a leader in the process of systemic change: “Change leaders, ‘create change strategy

that integrates people, process, and content needs, including how to change mindset and culture to support new business” (Anderson & Ackerman Anderson, 2001, p. 185). This could lead to successful innovation through community and stakeholder support, while supporting a cultural shift in mental health care thinking. The current climate of peer led services in mental health care is to develop national standards that govern this work. Developing a peer counselling program is potentially ahead of this process, as it supports professionalizing peer services that have not been researched, piloted, or standardized. However, “the personal-best leadership cases continue to be about radical departures from the past, about doing things that have never been done before, and about going places not yet discovered” (Kouzes & Posner, 2007, p. 163).

The engagement and communication with stakeholders and other community agencies could lessen the isolation of change management planning. It could also build support from larger health systems, both locally and on a national level, as was made clear by the insights offered by the expert interviewees in this inquiry. The experts explained that MHCC will have released standards for peer support work as a part of their mental health campaign. They also mentioned that peer support accreditation and certification will be an important factor in implementing peer services. Working together on these standards of care is important. This is, in part, because when a problem arises, the whole system can be affected, and it takes a whole system to implement change. Through seeking out resources, other research, and proper protocols/standards, problems can be addressed appropriately. As explained by Wheatley (2006), “A system is composed of parts, but we cannot understand a system by looking only at its parts. We need to work with the whole of a system, even as we work with individual parts or isolated problems” (p. 139). By getting support from the community and national agencies already doing

peer or counselling work, we can learn to innovate and advance the cause. According to Senge (2006), “Organizations grounded in systems thinking . . . can make a difference, by fostering collective rethinking and innovation and serving as a convener for microcosms of larger systems” (p. 349). The various components of the mental health system can work together to create a climate for peer work that is conducive to helping clients at higher levels. BCSSV could harness the already existing knowledge and support to explore the development of a peer counselling project and its potential for peer work.

Limitations of the Research

This research project had a variety of limitations in the data collection process. “Human inquiry, like any human activity, is both complex and almost always incomplete” (Stringer, 2007, p. 179). Although there were limitations, steps were taken to accomplish the collection of a diverse and rich set of data. However,

It is not usually possible to include all the people who should be included, to interview them for the extended periods warranted by interpretive inquiry, to follow up on all the relevant issues, and to deal with all the contingencies that arise. (p. 179)

According to Glesne (2011), “limitations are consistent with the partial state of knowing in social research” (p. 214). In this section, I explain the limitations arising from engaging in a research topic on the development of a peer counselling program and the actual stages of the research itself. This is inclusive of the backgrounds of the participants, lack of community involvement, and the limited abundance of academic literature in the field of peer work. The particular limitations of this research are detailed in this section.

Participants

Firstly, all participants of the focus group were purposively chosen and recruited. This research was conducted with a small sample size of board members. Only five board members participated in the focus group and interviews. There was also significant duplication of participants in the interviews and the focus group. Within the focus group, only one added board member came forward who had not been interviewed. To create a depth of sampling amongst participants, however, those included were people in recovery, family members of people in recovery, and professionals in the field of mental health.

The experts who were interviewed were both Canadians and have worked in similar areas with similar backgrounds relating to social justice and human rights in mental health care. This could have created a sense of generalizing the systemic effect of developing a peer counselling program and only present information from a localized view of peer services. However, some of the dialogue with the experts explained national-level trends and the current climate of peer services that supported the value of peer work.

Community engagement

The data collection was limited to BCSSV internal stakeholders, other than the two experts in the mental health field. The conversations were in-depth, like a case study, to learn the inner working of one organization; however, data were not gathered from multiple community stakeholders. The focus group and board member interview data were localized to BCSSV and are not generalizable to other organizations. These focus group and board member interview methods produced intimate data from within BCSSV that included information on fears, innovation, structural needs, and logistics. This may have limited any external viewpoints from

the larger community of peer service organizations; therefore, including the peer service experts was an attempt to include a larger perspective.

Lack of research

Research provides academic evidence for thematic topic areas and becomes useful for transformation purposes, especially as that research body grows. “The outcomes of scientific research are embodied in the technical achievements that continue to transform our modern world” (Stringer, 2007, p. 5). In the area of peer counselling for mental illness, where authentic peer support work is combined with professional level clinical counselling, research has been limited and was gathered from similar fields of study. This is a new area of study. In conducting this research project, there were multiple academic studies on peer support to utilize. However, the term peer counsellor was used to describe a peer supporter, but was not defined at the level of a professional/clinical and counselling-trained peer worker.

As this research covers new ground the conclusions have been founded upon the lived experiences of the board members and two experts in the peer field. These data are influenced by this lived knowledge that the participants shared, along with information provided through the literature, not through evidence-based empirical research on existing programs. It can be called a ‘practice informed’ process rather than evidence based.

Chapter Summary

Overall, the development of a peer counselling program may or may not contribute to the advancement of peer work. However, continuing the dialogue may illicit further thinking about the role in mental health systems of people in recovery from mental illness. Ethical considerations are important to understand to alleviate liability and structural issues in client

care. Some of these ethical dilemmas revolved around boundaries, disclosure, and human rights issues. Furthermore, quality of life enhancement for clients was a key focus in how a peer counselling program would be conducted.

Organizational readiness could be enhanced by a proper change management plan. A peer counselling program needs proper definition and parameters to be implemented appropriately. It also needs to become distinct from peer support. As the BCSSV dialogues about how to be innovative and gain support from funders, the parameters needed to sustain this program may become evident. However, there may or may not be liability issues to be addressed that could hinder taking action. Focusing on the strengths of peer services could enhance movement forward. That said, structures need to be put in place to prevent the potential liability issues.

Finally, BCSSV does not have to move forward alone. Through community engagement, they can understand the current national progress in peer services. They can understand the possibilities, opportunities, and client needs for peer counselling. They can create systemic transformation and advance the cause as leaders in change.

CHAPTER FIVE: INQUIRY IMPLICATIONS, RECOMMENDATIONS FOR THE ORGANIZATION, RESEARCH LIMITATIONS

In this chapter, I have focused on providing recommendations to the sponsoring organization. These recommendations were supported by both the research data and academic literature. I also explain the implications for the organization and for further research. The BCSSV stakeholders, including the Executive Director and board members, must work together to implement the recommendations. In any change initiative, “leaders, individually and collectively, work to bring about change. Their focus is invariably on the new, on what is trying to emerge” (Senge, 2006, p. 335). The change effort required to develop a peer counselling program is in- depth as the recommendations which follow will show. According to Goleman, Boyatzis and McKee (2002), “Change of the sort we are talking about requires effort, support, and resources . . . most . . . organizations revolve around the status quo, fighting off anything that threatens it, this level of change requires courageous leadership, stamina, and unswerving commitment” (p. 230). Through taking action on these recommendations, BCSSV can expand upon current practice, move toward innovation, and understand how a peer counselling service meets the needs of the mental health community.

Recommendations

The following recommendations were determined based upon the lived knowledge of the board member participants and the two experts in the peer field and the relevant literature. As this topic area has not been explored before the recommendations rely on this lived experience and not on more traditional forms of empirical evidence. Through this research process, four recommendations have been provided. They advise BCSSV of the direction they could take to

move toward the development of a peer counselling program. This is a change process, and the following recommendations support a change plan that moves the organization forward. The recommendations are not necessarily presented sequentially and could be implemented simultaneously.

Recommendation one: It is recommended in the next six months that the Executive Director and board members consult with the organizational stakeholders, such as VIHA, peer supporters, clients in recovery from mental illness, and their families, as part of a viability assessment to determine the support for the development of a peer counselling program.

It will take leadership commitment and engaging the stakeholders to unite the organization as ambassadors in enhancing peer service delivery through a viability assessment. “Even the best leadership development programs, if conducted in a vacuum, do little to foster the kind of change that organizations need today” (Goleman et al., 2002, p. 239). Peer counseling is a new program area that combines clinical practice with peer knowledge to serve clients, so it needs exploration by stakeholders to solidify a vision for its design. Many questions arose out of the interviews and focus group about what this program would entail and who would fund it. This means it needs to be explored both internally and externally through our stakeholders and community partners to discover whether it will be supported. It is suggested that the potential issues need to be addressed by the whole system that is involved. “Problems do not exist in isolation but are part of a complex network of events, activities, perceptions, beliefs, values, routines, and rules—a cultural system maintained through the life of the group, the organization, or community” (Stringer, 2007, p. 67). The data showed that the BCSSV board members were

concerned in particular about funding issues, liability, and the structure for such a program. By engaging with the community, BCSSV can explore the viability and steps needed to proceed. This includes accessing other agencies' funding proposals, document templates for the structural components of their mental health programs, manuals, and research for using peer models.

Kouzes and Posner (2007) stated,

By consulting with others and getting them to share information, you make certain that people feel involved in making decisions that affect them. This is no guarantee that a final decision will be accepted, but it's certain to decrease resistance. (p. 232)

Finding out the expectations of funders, insurance policy protocols, structure of similar programs by other agencies, and the needs of the client and their families could allay the fears involved in moving forward. The aim through recommendation one is to provide a directive that will focus BCSSV on the practicalities of whether a peer counselling program is viable in the eyes of all the stakeholders who would be affected. However, the work cannot only be done on an intellectual level; it needs to be emotional as well. "Through this important work of emotional engagement, they would create a learning community—teams of people who took the process of development and business growth seriously and who would challenge each other to change" (Goleman et al., 2002, p. 238).

Recommendation two: It is recommended in the next fiscal year that the Executive Director lead the development of an organizational Wellness Recovery Action Plan (WRAP) in conjunction with the board members, staff, and volunteers as a part of strategic planning regarding peer program development.

The WRAP process is already well implemented within BCSSV throughout the peer support team and as individual staff member plans. An area of further development would be to

create a WRAP for the organization as a whole. Copeland (2012) explained that “WRAP® is a self-management and recovery system developed by a group of people who had mental health difficulties and who were struggling to incorporate wellness tools and strategies into their lives” (para. 1). Although WRAP has been developed for individuals in recovery from mental illness, it could prove to be effective to create one to establish organizational safety nets. The issues of how to manage liability, conflict, funding challenges, and overall stakeholder concerns could be addressed in a WRAP context. Having a plan that defines the organization’s ability to manage risk taking and innovation safely, especially as it considers developing a peer counselling program, could set BCSSV up for future success and could be identified as part of strategic planning.

Strategic planning

Strategic planning is an investment in the organization. Stringer (2007) stated, “Strategic planning encompasses carefully defined and inclusive procedures that provide participants with a clear vision of their directions and intentions” (p. 149). It provides a direction into the future that is backed by present moment needs and values. Wheatley (2006) explained,

If there is no objective reality out there, then the environment and our future remain uncreated until we engage with the present. We must interact with the world in order to see what we might create. Through engagement in the moment, we evoke our futures. (p. 38)

In order to develop a plan for the future, the “strategic architecture” (Senge, 2006, p. 284) needs to be established. This is a system of ideas that guides the process involving theories, methods, and tools as well as infrastructural innovations that support organizational learning. A careful analysis of current practice, skill, relationships, belief, and assumption as well as awareness will

deepen the process (p. 284). Strategic planning brings clarity to the people involved in regards to the organizational activities. Stringer (2007) understood that “as their analysis reveals the factors with which they must contend, stakeholders may be able to rationalize their activities (p. 150). Planning becomes a tool for categorizing and putting activities into focus. “By planning . . . they are able to incorporate a diversity of activities into a few broad schemes or to connect a multitude of activities in ways that increase their effectiveness” (p. 150).

Incorporating WRAP into strategic planning will create a full wellness plan as the organization takes risks and innovates into unexplored areas. Copeland (2012) explained that typically,

WRAP is a structured system to monitor uncomfortable and distressing feelings and behaviors and, through planned responses, reducing, modifying, or eliminating them. It also includes plans for responses from others when you cannot make decisions, take care of yourself, or keep yourself safe. (para. 6)

BCSSV could utilize this tool in strategic planning through creating a sub-document that aims to help them manage organizational distress, safety issues, and risk to plan responses to these issues. As the purpose of strategic planning is to act as a directive for future focus, the addition of an organizational WRAP is in alignment with that vision. A strategic plan is “a simple framework involving an analysis of the internal strengths and weaknesses of the plan, and external opportunities and threats, guides this process” (Stringer, 2007, p. 153). A WRAP can provide a structure for dealing with the threats and weaknesses the organization may face.

Recommendation three: It is recommended in the next year that the BCSSV Executive Director and board members create clear parameters for a peer counselling role as distinct from peer support, including definition of peer

counselling, a job description, qualifications statement, training needs, and a plan for recruitment.

Through proper program development strategies that include building parameters for peer counselling work, BCSSV can support innovation in the realm of peer programming. In this regards, creating a distinction between the definitions of peer support and peer counselling would alleviate any grey areas in moving forward. Proper structures need to be put in place to support the successful venture of launching a peer counselling program. Overall, creating viable programs needs planning, analysis, and documentation that is thoughtfully designed to enhance productivity and sustainability. Wheatley (2006) stated, “The viability and resiliency of a self-organizing system come from its great capacity to adapt as needed, to create structures that fit for the moment” (p. 82). Proper structure is imperative for successful change management planning.

Building infrastructure

As BCSSV transitions toward any change plan, a strong infrastructure needs to be developed. Coghlan and Brannick (2010) explained an aspect to managing any change transition: “[Have] a strategic and operational plan which simply defines the goals, activities, structures, projects and experiments that will help achieve the desired state” (p. 68). This is because the unknown factors of program innovations can prevent organizations from moving forward. Senge (2006) stated, “Structures of which we are unaware hold us prisoner. Once we can see them and name them, they no longer have the same hold on us” (p. 149). Structures can sustain organizations. Although roles, definitions, insurance documents, and other program structures are necessary, Senge went on to stress that the organization “is not locked into any one structure; it is capable of organizing into whatever form it determines best suits the present situation” (p.

82). In order to adopt a new way of being, organizations need to have the defining program structures thoroughly established. Senge further explained that “either way, once an operating structure is recognized, the structure itself becomes the ‘current reality’” (p. 150). To create this new reality, BCSSV will need to enlist stakeholders on an emotional level and engage them in the process of building the new structure. This relates to the dynamics of a learning organization, such as BCSSV.

A tool to support BCSSV in understanding the structures that currently exist and enable the creation of new ones is the systems diagram. Anderson and Ackerman Anderson (2001) have shown that “the unique relationships among variables in a system create an underlying dynamic ‘structure’ . . . systems diagrams, which outline the organization’s underlying dynamic structure, assist systems thinkers to identify leverage points for change” (p. 148). BCSSV can utilize these types of diagrams to analyze, create, and understand how structures that exist can be improved or adapted towards the development of a peer counselling program.

Recommendation four: It is recommended over the next decade that BCSSV

Executive Director and board members engage in further research and leadership on standards of practice for programs involving peers at a higher level of service.

In order to proceed with the development of a peer counselling program, BCSSV may need to engage in more research to understand this unique concept and garner support from the community. Perhaps engaging with other organizations that are already established and learning about their resources may be a way to alleviate funding issues for research projects. Once organizational readiness is established, a plan needs to be created to discover the research needs of the community regarding peer work. A careful assessment of national, provincial, and local

peer services to locate gaps in knowledge may provide topic areas for future research. However, it is important to acknowledge that research is not only a way to focus on specific topics, but it may also create systemic change. Senge (2006) eloquently stated, “We are the seed carriers of the whole in the sense that we carry the mental models that pervade the larger system” (p. 348). Our vision, our mental models, and the messages we share of the system will influence other systemic ideas. Senge further explained that “we can either think and act in ways that reinforce the system as it currently operates, or think and act in ways that lead in different directions” (p. 348). Research can affect system change.

Research for system change

Another facet of research is to create systemic change. In regards to peer work, this may include a new ideology on the extent of such practice. New meaning of what peer work is that relates to inclusion, human rights, and participation in professionalism needs to be established. “If the work of change is at the level of an entire organization or community, then the search for new meaning must be done as a collective inquiry” (Wheatley, 2006, p. 148). It is BCSSV’s work to provide opportunity to people in recovery as a form of social inclusion. It could also be an opportunity for BCSSV to engage in research that explores system-wide transformation of perceptions of peer work, and such research could be a catalyst for change. Senge (2006) stated, “It is here that organizations grounded in systems thinking . . . can make the difference, by fostering collective thinking and serving as a convener for microcosms of larger systems” (p. 349).

Research processes like “systemic questioning . . . can create formulation of tentative working explanations as to what is happening in the system, . . . and the circuitry, patterns,

covert rules, meanings, and time—may uncover the dynamic complexity of the system” (Coghlan & Brannick, 2010, p. 94). Once the organization understands the systemic structure, it can work towards asking research questions that offer insights that create change, fill gaps, and evolve practices. This may be possible due to the interdependence of systems (p. 93). As BCSSV explores research topics, gathering evidence through various methods and supporting academic literature, it would begin a systemic change process. Overall, research is an important vehicle for understanding and integrating new realities into systemic design. As with any research, there are also implications the organization must consider.

Organizational Implications

There are a range of implications that will affect change management processes at BCSSV as it considers taking action on the development of a peer counselling program. Ideologies such as fear, evidenced-based supports, community supports, and overall viability can hinder the transition. To support moving forward through these issues, change takes careful planning and developing a critically thought-out strategy. BCSSV must understand the implications that this research portrays and the importance of the change process in order to maintain itself: “Change is prompted only when an organism decides that changing is the only way to maintain itself” (Wheatley, 2006, p. 20). Changing and innovating may be the only option for survival in today’s non-profit sector climate: “Any living thing will change only *if it sees change as a means of preserving itself*” (p. 147).

Internal implication regarding fear of change

Fear of change is disabling at best, unless an organization takes the risk through proper planning. Creating a negative vision based on fear of liability will prevent innovation from

occurring. As explained by Senge (2006), “Negative visions are limiting . . . energy that could build something new is diverted to “preventing” something we don’t want to happen . . . negative visions carry a subtle . . . message of powerlessness . . . negative visions are inevitably short term” (p. 209). Senge went on to explain that fear is part of a negative vision for change:

There are two fundamental sources of energy that can motivate organizations: fear and aspiration. The power of fear underlies negative visions. The power of aspiration drives positive visions. Fear can produce extraordinary changes in short periods, but aspiration endures as a continuing source of learning and growth. (p. 209)

Overall, positive aspirations to make change can procreate long-term learning and organizational growth that a fear-based process does not. BCSSV needs to take a positive look at itself as an organization in development. Key leaders in the organization need to understand when change is too much and when they are holding back too much. In defining roles of the internal structures for establishing the viability of a peer counselling program, BCSSV must face its fear, such as fear of liability. It takes looking at policy, practice, financial issues, and roles. However, “we are afraid of what would happen if we let these elements of the organization recombine, reconfigure, or speak truthfully to one another. We are afraid that things will fall apart” (Wheatley, 2006, p. 19). By organizational nature, BCSSV will find a way to succeed. The leadership stakeholders of the organization will continue to establish the necessary resources to sustain the organization. BCSSV will not, not learn. “This is a universe, we feel, that cannot be trusted with its own processes for growth and development. If we want progress, then we must provide the energy to reverse decay” (p. 19). Trusting the universe, the organization’s ability to thrive is a key factor in facing its fear: “By sheer force of will, because we are the planet’s intelligence, we will make the world work. We will resist death” (p. 19).

Visionary implications for the mental health system

BCSSV has an opportunity to create a vision for peer work for the larger mental health system through this research process and its recommendations. The vision of a peer counselling program that this research explored had not been done before in peer-related mental health services. This could be a time of visioning for innovation and addressing the barrier between professional and peer services in some way. At the very least, BCSSV could continue its legacy of a remarkable reputation in mental health care through further research. The larger system is currently evaluating peer support care and creating standards of practice to govern the work. There is also a human rights lens being integrated into these practices. Stigma still exists towards people with mental illness, and BCSSV can support a change to such negative perceptions and offer more opportunities for their contributions in developing a shared vision: “Shared visions emerge from personal visions” (Senge, 2006, p. 197). The BCSSV vision can influence a shared systemic vision.

External implications involving community

BCSSV will need to build alliances and relationships with community stakeholders that will aid in the change process. Engaging with key players in the mental health field would set a tone for successful supports for the change management implementation plan. The mental health community needs to be interconnected for successful client care and vibrancy. Anderson and Ackerman Anderson (2001) stated it is important to “build and sustain relationships between organizational entities to enhance mutual and system-wise effectiveness” (p. 122). These community partners may have access to resources, funding sources, risk management processes, and evidence-based mental health practices to build upon. These tools could be utilized for

building upon a new area of peer service such as peer counselling. “Change leaders must fully attend to the interdependencies of change processes. Change leaders must build bridges across functions, processes, stakeholder groups, and change initiatives to ensure collaboration, information sharing, and shared accountability for enterprise outcomes” (p. 122). A connected, supportive community of organizations enables systemic growth and sustainability.

Organizations like the Mood Disorders Association, the Canadian Mental Health Association, and the Mental Health Commission of Canada are allies in mental health work and could provide collaborative measures, information sharing, and research to support further exploration of a peer counselling innovation. All stakeholders could answer questions about the meaning of change processes and direct the BCSSV towards viable next steps.

Organizational response

Kouzes and Posner (2007) stated, “You have to spend more of today thinking more about tomorrow if your future is going to be an improvement over the present” (p. 113). Although the BCSSV cannot commit to taking action at this time in regards to every recommendation they are in the planning stages of developing a strategic plan and going through a reflection process for future organizational focus. They were impressed with the idea of an organizational WRAP and thought it would be an important part of this process. Furthermore, questions arose about what they would and would not do moving forward. Overall, they were impressed with this research paper and acknowledged the amount of work done to complete it. Further discussion will be had in moving forward with the strategic plan while keeping this paper in mind. In addition, they agreed that further research was also an interest and the next section explains areas for future exploration. There was also commentary on peer counselling as an innovative idea and that there

could be potential to develop it after careful dialogue with external stakeholders and a needs assessment.

Implications for Future Inquiry

Due to the limited research on peer services there is potential to cover many more topic areas on the subject through further research studies. Topics as such as peer roles and innovation, advancing peer potential, professionalism and peer work crossover, and peer counselling from a clinical lens would support the perception of working as a person in recovery within the overall mental health system. Furthermore, research that promotes and explores the human rights of people with mental illness to be integrated into mental health work would support anti-stigma campaigns. The United Nations Convention on the Rights of Persons with Disabilities wants to make sure “the human rights of all persons with disabilities are promoted and protected . . . by taking steps to eliminate barriers to the full participation of people with health problems and illnesses in schools, workplaces, and other sectors as well as in communities in general” (MHCC, 2012, p. 33). Research that supports understanding the barriers to employment in professional settings could provide context to system work that needs to be done to advance peer work.

Standards and practices for mental health care need to address the levels of integration that peers are allowed to have presence in within the system and move toward further client engagement. Researching how these standards restrict and promote peer work will provide a knowledge base from which to create change. “Guidelines, indicators, tools, competencies, standards, curricula, leadership, on-going training and education, policies and legislation can all pay a role in reorienting policy and practice” (MHCC, 2012, p. 28). Research on the strengths

and weaknesses of current practice may provide some insight to a more recovery oriented system for both peer employment and individual care. Currently, there is a barrier between peers being in support roles and advancing on to professional employment. It would be advantageous to gather statistical data from mental health employers regarding disclosed peer roles at higher levels. This would provide an understanding of how standards of practice prevent persons with mental health disabilities from entering the workforce.

Finally, there is importance to honouring the mental health journey of people in recovery. Future research must include peers as investigators, knowledge sharers and active participants. The insights they have into systems, processes, community resources, care provider attitudes and barriers to community integration, which includes stigma, discrimination and social isolation can enhance mental health work in a positive way.

People living with mental health problems and illnesses and their family members are 'experts by experience.' International evidence shows that the active involvement of people with lived experience and their families in decision making at all levels is key to system change (MHCC, 2012, p. 31)

Overall, this work must have meaning and value and go beyond volunteerism into paid employment status and be as respected as professionalized service. This type of research experience would then support non-discriminatory practice and social inclusion for all people affected by mental illness.

Chapter Summary

Overall, the four recommendations cover areas of viability, wellness and strategic planning, structural development, and engagement in future research on peer services. These were discussed as a potential direction for the organization as it considers developing a peer

counselling program. They are not designed to be a step-by-step plan for change management and could be implemented simultaneously. “The challenge for us is to see past the innumerable fragments to the whole, stepping back far enough to appreciate how things move and change as a coherent entity” (Wheatley, 2006, p. 43). Seeing the whole picture will aid in the transformation process, and action can be taken toward the end goal of the organization.

CHAPTER SIX: META-REFLECTION ON INQUIRY

The information provided in this chapter focuses on recommendations for and the implications to the field of academic research. Details to be discussed include: the quality of participation in the research process for both the researcher and participant and the relationships in the change process, the researcher's personal learning about the issue, the next steps for the organizational stakeholders and the contribution to the knowledge for both the researcher, other areas and the broader social context.

Action Research Process

“The central idea is that action research uses a scientific approach to study the resolution of important social or organizational issues together with those who experience these issues directly” (Coghlan & Brannick, 2010, p. 5). This was “a collaborative, democratic partnership” (p. 5). As the participation rate for board members was limited for the focus group, in retrospect, I would have utilized the knowledge and expertise of my BCSSV sponsor and project supervisor more extensively to develop a stakeholder engagement plan. According to Goleman, Boyatzis and McKee (2002), “What leaders must do is find a way to get executives emotionally engaged with each other and with their visions, and see to it that they begin to act on those visions” (p. 239). Furthermore, as a part of a stakeholder engagement plan, I would have improved the communication strategy for the vision of the project. “Leaders must breathe life into visions, they must animate them so that others can experience what it would be like to live and work with that ideal and unique future” (Kouzes & Posner, 2007, p. 152). Overall, communication of vision, meaning and purpose can enliven stakeholders to unite for the benefit of the larger context in action research.

Quality of participation

The quality of participation is integral to a research project. It can also support or hinder change management processes. Overall, the participation in this research project on the topic of peer counselling added value to the data, conclusions and recommendations. The participation of both the researcher and participants will be discussed below.

Researcher

“Organizations learn only through individuals who learn” (Senge, 2006, p. 129). The topic area is one I had a high level of interest in learning about. As a participant in implementing, structuring and analyzing the process, my heart was in the work. It was this sense of passion for the people, process and data that enabled my presence for participation. “Passion and attention go hand in hand. People don’t see the possibilities when they don’t feel the passion” (Kouzes & Posner, 2007, p. 113). I was an active, aware, sensitive, attentive and dedicated researcher. “Sensitivity to others is no trivial skill; rather, it is a truly precious human ability. But it isn't complex: it requires receptiveness to other people and a willingness to listen” (p. 119).

Participants

The participants in this research study were dedicated to the process of not only openly sharing viewpoints, exploring ideas and answering questions that led to important insights, but to also reflecting on the dialogue for this project. Senge (2006) stated, “Reflective openness leads to looking inward, allowing our conversations to make us more aware of the biases and limitations in our own thinking, and how our thinking and actions contribute to problems” (p. 261). Each participant contribution complimented the ideas of the others to establish a set of data that was rich with diverse knowledge on the topic. In regards to a leader’s traits, Kouzes and Posner

(2007) explained, “The most striking similarities we’ve found . . . is the list is populated by people with *strong beliefs about matters of principle*. They all are, or were, passionate about their causes” (p. 46). This statement is true for each of the participants in this research project.

Relationships in the change process

The discussion with board members in the focus group was imperative for future planning and program implementation. Outside of their confidential role in the research their relationships as leaders within the organization can support taking action on recommendations. Through working in collaboration these organizational stakeholders can support change management processes for success in program development. Kouzes and Posner (2007) stated, “To get extraordinary things done, you have to promote a sense of mutual dependence – feeling part of a group in which everyone knows they need others to be successful” (p. 243).

It also takes building relationships with experts in the mental health field, families and other health professionals to support the advancement of peer services. This could be accomplished through collaborating to transform systemic processes like government policy and national standards. The BCSSV stakeholders can act as agents of change and work alongside the experts as catalysts for the same cause. These relationships can be forged through building mutual participation/exchange in projects, research studies and involvement in mental health campaigns. “Cooperative goals and roles contribute to a sense of collective purpose, and the best incentive for others to work to achieve your shared goals is their knowing you will reciprocate” (Kouzes & Posner, 2007, p.243). This inquiry has planted the seeds for this collaborative commitment to systemic change.

Personal Learning about the Issue

Peer support is a valued modality for providing empathetic and understanding care to clients with mental illness. People in recovery, working in the mental health field, have a set of skills from resourcefulness, insider knowledge and deep compassion for others, to insights into managing illness. However, although this work and lived experience is valued overall, it has limits and parameters around being integrated into multiple higher level mental health systems as of the time of this research. There is a strong division between support work done by people in recovery and clinical work done by health care professionals. The MHCC (2012) stated,

A pan-Canadian workforce education and development strategy could enable the development of core competencies common to all mental health professional disciplines, shape interdisciplinary training guidelines, and help to build bridges to other sectors . . . such a strategy could create opportunities for people living with mental health problems and illnesses to take up positions at all levels of the mental health workforce.” (p. 90)

The integral learning I garnered from this research process is that people in recovery need to be integrated into health systems as researchers, employees, ambassadors for change, advocates, professionals and specialists. Further to this idea of utilizing the value of client knowledge, is to look at where the system is still falling short in the integration process. The system needs to realign standards of practice with human rights and social justice to include peers in work that is usually done by professionals, if the peers are capable of attaining the level of education required for that work. I also extended my understanding of the complexity of the work that needs to be done organizationally to create the infrastructure and readiness for this transformation.

Contribution to the Knowledge

Sharing ideas with an innovative focus creates new territory for academia and supports the unknown becoming known. “One of an organization’s most critical competencies is to create

the conditions that both generate new knowledge and help it to be freely shared” (Wheatley, 2005, p. 110). This research project offered insights into understanding the potential to advance peer work and integrate it into professional mental health work. Currently, this idea challenges perceptions of peer work capacity, including the human rights towards employment for people in recovery and the contributions peers can make to the larger system. The sections below explain two areas of contribution to the knowledge: that of myself as the researcher, and the broader social context.

Self

As a contributor to mental health research, I’ve discovered areas that need further attention/development related to human rights, employment status for people with mental illness and other barriers to inclusion. By undertaking an exploration of peer counselling I hope to have supported a new view of what people in recovery could be capable of. According to Kouzes and Posner (2007), “Every organization, every social movement begins with a dream” (p. 17). Whether it is viable or not, my hope is to have opened a door to understanding the importance of the inclusion of people in recovery from mental illness in professional settings. Without having a leader who can create the vehicle for new conversations, change may not occur in areas where change is needed. Goleman, Boyatzis and Deal (2002) stated, “Leaders who can catalyze change are able to recognize the need for change, challenge the status quo, and champion the new order” (p. 256). I hope to have been a contributing leader in this capacity.

Broader social context

People with mental illness and their families have value to mental health systems. People often embrace recovery and move on to employment and education. If we create/maintain

systems that put up barriers to recovery it procreates stigma. It also prevents those with mental illness from making contributions toward healthcare improvements that are more client centered. A healthy system socially accepts the insight of people who have experienced hospitalization, case management, poverty, homelessness and psychosis or addictions.

Chapter Summary

The aim of this chapter was to explore meta-reflections on the action research process. This included the quality of participation of the researcher, the participants and the relationships in the change process. Also discussed was personal learning about the issue and the contribution to the knowledge for the researcher and to the broader social context. Overall, the process built a strong basis upon which a peer counselling program could be developed. The participants offered insight, knowledge and experience from a variety of perspectives. The contribution to the research can be regarded as new territory, an exploration of the potential for peer services and people in recovery.

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APPENDIX A: EXPERTS LETTER OF INVITATION (INTERVIEW)

The Development of a Peer Counselling Program at the BC Schizophrenia Society Victoria

(Date)

Dear (Potential Participant Name),

My name is Tara Timmers. In partial fulfillment of the requirements for a Master of Arts-Leadership (Health) Degree at Royal Roads University, I will be conducting an action research study at the BC Schizophrenia Society Victoria (BCSSV) to explore the development of a peer counselling program. My credentials with Royal Roads University can be established by calling Dr. Brigitte Harris, Director, School of Leadership Studies, Royal Roads University, at [phone #].

You are being approached for your expertise in the field of peer support. As a participant, you may contribute to peer research, share insights, and support the discovery of potentially innovative programming for BCSSV.

As a voluntary participant you would be involved in a 60 minute one-on-one interview with me, which will be held over the phone on a mutually agreeable date in the next two weeks. You are invited to participate on a voluntary basis and are not compelled to do so. At no point during the research process will you be coerced to participate or deceived in any way. Should you choose to volunteer to be interviewed, you can choose to withdraw at any time. The interview will be on speaker phone and will be digitally recorded, and you can request at any point during the interview that the recording device be turned off and then turned on again. Your identity as an interviewee will remain confidential, and your anonymity will be respected in all reporting of the findings. At no time will you be identified in the reporting of findings without your explicit prior agreement in writing. You can choose to withdraw at any time and the information you provided during the interview will not be included as long as your withdrawal occurs before the information has been analyzed. If you withdraw after the data has been analyzed the information you have contributed will be kept as part of the research project. All digital recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from me and no one else will have access to the recordings. Upon completion of the transcription process (approximately one week after the interview), you will be asked to check the accuracy and completeness of your transcribed interview within 48 hours of you receiving them by email and you may at that time request any revisions, additions or deletions.

The information gathered from this research process will be used to develop recommendations to the BCSSV. The recommendations will inform the board of potential for a peer counselling program development in the organization. The findings and the conclusions drawn will be reported and included in the final thesis document. As this research will also be

published, a copy of this thesis will reside in the Royal Roads University library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal and the ProQuest/UMI database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The data will be stored for the timeline of one year after the final report has been accepted by Royal Roads University in compliance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After one year all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

The questions you will be asked in the interview are as follows:

1. In your experience through your work with the peer movement what are the current global and national trends in peer service development?
2. In your experience, what are your views of the recovery movement on the development of peer counselling programs?
3. How would human rights and social justice effect the development of a clinical peer counselling program?
4. What provincial or national standards are in place to support clinical peer practice in a healthcare setting?
5. If the BCSSV were to develop a peer counselling program what risks might they encounter?
6. Is there a body of research or similar programs being created from other jurisdictions that would support the development of a peer counselling program here in BC?
7. How would you argue the case for the development of a peer counselling program in regards to professional/clinical peer work?
8. In your opinion, what are the differences between peer support and peer counselling?
9. Is there anything else you would like to comment on that has not been mentioned, given the focus of this inquiry?

Please contact me by return email within one week to indicate your availability to participate in the research study. If you have any questions you can contact me at [phone #] or [email address].

Sincerely,

Tara Timmers

APPENDIX B: BOARD LETTER OF INVITATION (INTERVIEW)

The Development of a Peer Counselling Program at the BC Schizophrenia Society Victoria

(Date)

Dear (Potential Participant Name),

My name is Tara Timmers. In partial fulfillment of the requirements for a Master of Arts-Leadership (Health) Degree at Royal Roads University, I will be conducting an action research study at the BC Schizophrenia Society Victoria (BCSSV) to explore the development of a peer counselling program. My credentials with Royal Roads University can be established by calling Dr. Brigitte Harris, Director, School of Leadership Studies, Royal Roads University, at [phone #].

As a participant, you may contribute to peer research, share insights, and support the discovery of potential innovation.

As a voluntary participant you would be involved in a one-on-one interview with me, which will be held over the phone on a mutually agreeable date in the next two weeks and the interview is expected to last for 60 minutes. You are invited to participate on a voluntary basis and are not compelled to do so. At no point during the research process will you be coerced to participate or deceived in any way. Should you choose to volunteer to be interviewed, you can choose to withdraw at any time. The interview will be digitally recorded and you can request at any point during the interview that the recording device be turned off and then turned on again. Your identity as an interviewee will remain confidential and your anonymity respected in all reporting of the findings. At no time will you be identified in the reporting of findings without your explicit prior agreement in writing. You can choose to withdraw at any time and the information you provided during the interview will not be included provided that your withdrawal occurs before the information has been analyzed. If the you withdraw after the data have been analyzed the information you have contributed will be kept as a part of the research project. All digital recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings. Upon completion of the transcription process (approximately one week after the interview) you will be asked to check your portion of the transcribed data for accuracy within 48 hours of receiving them by email.

The information gathered from this research process will be used to develop recommendations to the BCSSV. The findings and the conclusions drawn will be reported and included in the final thesis document. The recommendations will inform the board, about the potential for peer program development in the organization. As this research will also be published, a copy of this thesis will reside in the Royal Roads University library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/UMI

database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The data will be stored for the timeline of one year after the commencement of the research project. This is as to follow Royal Roads University guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After one year all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

The questions you will be asked in the interview are as follows:

1. What do you know about the risks and strengths of peer led services in mental health care in supporting clients?
2. Tell me about a time when you felt that the BCSSV was truly supporting its clients through peer resources. What was it about that time that made it so memorable to you? If you don't have a time in mind, what would you envision supportive peer service to look like?
3. If you were to imagine a future for BCSSV that included an extension of our peer support role, to include a new peer counselling program, what might this new program involve?
4. What do you see as the strengths of the current peer support program and how might these strengths be utilized as the BCSSV considers the possibility of a peer counselling program?
5. In your experience, are there any differences between these two programs that the BCSSV would need to keep in mind?
6. What would it take to successfully develop a clinical peer counselling position at the BCSSV.
7. What are your thoughts on disclosure of self-recovery from mental illness in a professional peer counselling role?

Please contact me within one week to confirm your participation in the research study. If you have any questions, you can contact me at [phone #] or [email address]

Sincerely,

Tara Timmers

APPENDIX C: LETTER OF INVITATION (FOCUS GROUP)

The Development of a Peer Counselling Program at the BC Schizophrenia Society Victoria

(Date)

Dear (Potential Participant Name),

The purpose of this letter is to invite you to participate in an Action Research project hosted by the BC Schizophrenia Society Victoria (BCSSV) as a requirement of my Master's in Leadership Health program at Royal Roads University. This project is to develop recommendations toward advising BCSSV on actions to take towards the development of a Peer Counselling program. As a participant you may contribute to the body of knowledge of peer research, share insights and support the discovery of potential innovation. My credentials with Royal Roads University can be established by calling Dr. Brigitte Harris, Director, School of Leadership Studies, Royal Roads University, at [phone #].

As a participant you would be involved in a focus group method, which will be held on Sunday July 28th, 2013. The focus group process will last 80 minutes. The location will be the boardroom at the BCSSV office. You will be invited along with the rest of the Board members to participate on a voluntary basis and you can decline to do so without prejudice. At no point during the research process will you be coerced to participate or deceived in any way. You can choose to withdraw at any time and the information you provided during the focus group will not be included provide that your withdrawal occurs before the information has been analyzed. If you withdraw after the data have been analyzed the information you have contributed will be kept as a part of the research project.

Because of the group nature of a focus group, your identity will be known to other members of the group. However, all contributions made by you to the discussion will remain strictly anonymous in the reporting of the findings. At no time will any comments be attributed to you in that reporting without your prior expressed permission in writing.

I will facilitate the focus group along with one of my classmates from Royal Roads University who will be available to take notes on a flip chart and make sure consent forms have been signed prior to the start of the focus group. This focus group will take an hour and 20 minutes. The focus group will be digitally recorded with the option for participants to ask for the recording device to be turned off for a period of time as needed. The recording will be turned back on when the participants are ready to resume the focus group. All digital recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from me and no one else will have access to the recordings. Upon completion of the transcription process (approximately one week after the focus group) you will be asked to check your portion of the transcribed data for accuracy within 48 hours of receiving them by email.

The information gathered from this research process will be used to develop recommendations to the BCSSV. The conclusions drawn will be reported and included in the final thesis document. This document will be published and made available as an academic paper in print. The recommendations will inform the board, staff and volunteers about the potential for peer program development in the organization. As this research will also be published, a copy of this thesis will reside in the RRU library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/ UMI database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The data will be stored for the timeline of one year after approval of the final report by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After one year all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

At the commencement of the focus group you will be asked to select a pseudonym and to use that each time you speak. As a member of the focus group, you will be expected to treat as confidential the identity of all other members of the group and to not discuss the content of the focus group discussions with anyone outside the focus group.

All participants will be in agreement to keep all data heard, witnessed and shared as confidential from any external or internal organization sources. Although I have established due diligence in creating a confidential space there is no guarantee that this will be followed 100% by all participants. The focus group discussion will be digitally recorded for data collection and analysis. The recordings will be stored in a secure place and be kept confidential. No name will be used in the transcription and coding of the data. All flip chart recordings will also remain anonymous for the purposes of confidentiality. The data will also be transcribed, themed and coded for use in the final thesis report without disclosing the identity of the participants.

The questions that will frame the focus group session will be as follows:

1. What are the benefits of a peer counselling program for our organization?
2. What are the drawbacks or risks to a peer counselling program, in your opinion what are they?
3. In your experience what makes for successful peer led services and what advantages do they offer over professional counselling?
4. In your opinion, how can the BCSSV differentiate between Peer Counselling and Peer Support so as to not duplicate services?
5. Are you aware of any concerns, risks of challenges about the combination of peer work and professional practice that need to be considered?

6. What kinds of qualifications should a Peer Counsellor have? How does that differ from other peer programs?
7. What other programs that exist in Victoria BC are similar to Peer Counselling and what relevance might they have for BCSSV as it contemplates the possibility of moving in this program direction?
8. Is there anything else you'd like to share with me, that I haven't asked you about?

Please contact me within one week to confirm your participation in the research study. If you have any questions, you can me at [phone #] or [email address].

Sincerely,

Tara Timmers

APPENDIX D: EXPERTS INFORMED CONSENT (INTERVIEW)

The Development of a Peer Counselling Program at the BC Schizophrenia Society Victoria

The purpose of this document is as an agreement to consent to participate in a research project for the BC Schizophrenia Society Victoria (BCSSV). The research is being conducted by Tara Timmers, Administrative Coordinator at BCSSV on the topic of: How the BCSSV can develop a Peer Counselling Program? This is a requirement of the Masters in Leadership Health program at Royal Roads University.

As a voluntary participant you would be involved in a one-on-one interview with me, which will be held over the phone on a mutually agreeable date in the next two weeks and the interview is expected to last for 60 minutes. You are invited to participate on a voluntary basis and are not compelled to do so. At no point during the research process will you be coerced to participate or deceived in any way. Should you choose to volunteer to be interviewed, you can choose to withdraw at any time. The interview will be on speaker phone and will be digitally recorded, and you can request at any point during the interview that the digital recorder be turned off and then turned on again. Your identity as an interviewee will remain confidential, and your anonymity will be respected in all reporting of the findings. At no time will you be identified in the reporting of findings without your explicit prior agreement in writing. You can choose to withdraw at any time and the information you provided during the interview will not be included provided that your withdrawal occurs before the information has been analyzed. If you withdraw after the data has been analyzed the information you have contributed will be kept as a part of the research project. Upon completion of the transcription process (approximately one week after the interview), you will be asked to check the accuracy and completeness of your transcribed interview within 48 hours of your receiving them by email and may at that time request any revisions, additions or deletions.

The information gathered from this research process will be used to develop recommendations to the BCSSV. The recommendations will inform the board about the potential for peer program development in the organization. The findings and the conclusions drawn will be reported and included in the final thesis document. As this research will also be published, a copy of this thesis will reside in the Royal Roads University library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal and the ProQuest/UMI database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The data will be stored for the timeline of one year after approval of the final report by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After one year all paper

copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

In signing this form all participants are in agreement to keep all data heard, witnessed and shared as confidential from any external or internal organization sources. Although the researcher has established due diligence in the creating a confidential space there is no guarantee that this will be followed 100%. The interview will be digitally recorded for data collection and analysis. The digital recording will be stored in a secure place and be kept confidential. No name will be used in the transcription and coding of the data. The data will also be transcribed, themed and coded for use in the final thesis report without disclosing whom the participants were. All digital recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings. Upon completion of the transcription process (approximately one week) you will be asked to check your portion of the transcribed data for accuracy within 48 hours of receiving them by email.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB. These will be kept separate and apart so that no external viewer can decipher the participants' identity.

If you have any questions, you can me at [phone #] or [email address]

The signature you provide below is your agreement and understanding of the above protocols and is an informed consent to participate in the study. You will receive a signed copy of this form.

Name (please print): _____

Date: _____

Signature: _____

APPENDIX E: BOARD INFORMED CONSENT (INTERVIEW)

The Development of a Peer Counselling Program at the BC Schizophrenia Society Victoria

The purpose of this document is as an agreement to consent to participate in a research project for the BC Schizophrenia Society Victoria (BCSSV). The research is being conducted by Tara Timmers, Administrative Coordinator at BCSSV on the topic of: How the BCSSV can develop a Peer Counselling Program? This is a requirement of the Masters in Leadership Health program at Royal Roads University. My credentials with Royal Roads University can be established by calling Dr. Brigitte Harris, Director, School of Leadership Studies, Royal Roads University, at [phone #].

As a voluntary participant you would be involved in a one-on-one interview with me, which will be held over the phone on a mutually agreeable date in the next two weeks and the interview is expected to last for 60 minutes. You are invited to participate on a voluntary basis and are not compelled to do so. At no point during the research process will you be coerced to participate or deceived in any way. Should you choose to volunteer to be interviewed, you can choose to withdraw at any time. The interview will be on speaker phone and will be digitally recorded, and you can request at any point during the interview that the digital recorder be turned off and then turned on again. Your identity as an interviewee will remain confidential, and your anonymity will be respected in all reporting of the findings. At no time will you be identified in the reporting of findings without your explicit prior agreement in writing. You can choose to withdraw at any time and the information you provided during the interview will not be included provided that your withdrawal occurs before the information has been analyzed. If you withdraw after the data have been analyzed the information you have contributed will be kept as a part of the research project. Upon completion of the transcription process (approximately one week after the interview), you will be asked to check the accuracy and completeness of your transcribed interview within 48 hours of your receiving them by email and may at that time request any revisions, additions or deletions.

The information gathered from this research process will be used to develop recommendations to the BCSSV. The recommendations will inform the board about the potential for peer program development in the organization. The findings and the conclusions drawn will be reported and included in the final thesis document. As this research will also be published, a copy of this thesis will reside in the Royal Roads University library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal and the ProQuest/UMI database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The data will be stored for the timeline of one year after approval of the final report by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed

the recordings will be erased and deleted from the recording device. After one year all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

In signing this form all participants are in agreement to keep all data heard, witnessed and shared as confidential from any external or internal organization sources. Although the researcher has established due diligence in creating a confidential space there is no guarantee that this will be followed 100%. The interview will be recorded for data collection and analysis. The digital recording will be stored in a secure place and be kept confidential. No name will be used in the transcription and coding of the data. The data will also be transcribed, themed and coded for use in the final thesis report without disclosing whom the participants were. Upon completion of the transcription process (approximately one week after the interview) you will be asked to check your portion of the transcribed data for accuracy within 48 hours of receiving them by email.

If you have any questions, you can me at [phone #] or [email address]

The signature you provide below is your agreement and understanding of the above protocols and is an informed consent to participate in the study. You will receive a signed copy of this form.

Name (please print): _____

Date: _____

Signature: _____

APPENDIX F: INFORMED CONSENT (FOCUS GROUP)

The Development of a Peer Counselling Program at the BC Schizophrenia Society Victoria

The purpose of this document is as an agreement to consent to participate in a research project for the BC Schizophrenia Society Victoria (BCSSV). The research is being conducted by Tara Timmers, Administrative Coordinator at BCSSV on the topic of: How the BCSSV can develop a Peer Counselling Program? This is a requirement of the Masters in Leadership Health program at Royal Roads University. My credentials with Royal Roads University can be established by calling Dr. Brigitte Harris, Director, School of Leadership Studies, Royal Roads University, at [phone #].

As a participant you would be involved in a focus group method, which will be held on (insert date). The focus group process will last an hour and 20 minutes. The location will be the boardroom at the BCSSV office. You will be invited along with the rest of the Board members to participate on a voluntary basis and you can decline to do so without prejudice. At no point during the research process will you be coerced to participate or deceived in any way. You can choose to withdraw at any time and the information you provided during the focus group will not be included provided that your withdrawal occurs before the information has been analyzed. If the you withdraw after the data have been analyzed the information you contributed will be kept as a part of the research project.

Because of the group nature of a focus group, your identity will be known to other members of the group. However, all contributions made by you to the discussion will remain strictly anonymous in the reporting of the findings. At no time will any comments be attributed to you in that reporting without your prior expressed permission in writing.

I will facilitate the focus group along with one of my classmates from Royal Roads University who will be available to take notes on a flip chart and make sure consent forms have been signed prior to the start of the focus group. This focus group will take an hour and 20 minutes. The focus group will be taped with the option for participants to ask for the tape to be turned off for a period of time as needed. The digital recording will be turned back on when the participants are ready to resume the focus group. All data recordings will be transcribed by an external transcriptionists who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings. Upon completion of the transcription process (approximately one week after the interview) you will be asked to check your portion of the transcribed data for accuracy within 48 hours of receiving them by email.

The information gathered from this research process will be used to develop recommendations to the BCSSV. The conclusions drawn will be reported and included in the final thesis document. This document will be published and made available as an academic paper in print. The recommendations will inform the board, staff and volunteers about the potential for

peer program development in the organization. As this research will also be published, a copy of this thesis will reside in the RRU library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/ UMI database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The data will be stored for the timeline of one year after the final report has been approved by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After one year all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

In signing this form all participants are in agreement to keep all data heard, witnessed and shared as confidential from any external or internal organization sources. Although the researcher has established due diligence in the creating a confidential space there is no guarantee that this will be followed 100% by all participants. The focus group discussion will be digitally recorded for data collection and analysis. The digital recordings will be stored in a secure place and be kept confidential. No name will be used in the transcription and coding of the data. All flip chart recordings will also remain anonymous for the purposes of confidentiality. The data will also be transcribed, themed and coded for use in the final thesis report without disclosing whom the participants were. All digital recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings.

At the commencement of the focus group you will be asked to select a pseudonym and to use that each time you speak. As a member of the focus group, you will be expected to treat as confidential the identity of all other members of the group and to not discuss the content of the focus group discussions with anyone outside the focus group.

If you have any questions, you can me at [phone #]or [email address]

The signature you provide below is your agreement and understanding of the above protocols and is an informed consent to participate in the study. You will receive a signed copy of this form.

Name (please print): _____

Date: _____

Signature: _____

APPENDIX G: INQUIRY TEAM MEMBER LETTER OF AGREEMENT

In partial fulfillment of the requirement for a Master of Arts in Leadership Degree at Royal Roads University, Tara Timmers, (the Student) will be conducting an inquiry research study at *the BC Schizophrenia Society Victoria* to find recommendations toward the question: *How can the BC Schizophrenia Society Victoria develop a Peer Counselling Program.* The Student's credentials with Royal Roads University can be established by calling Dr. Brigitte Harris, Director, School of Leadership Studies, Royal Roads University, at [phone #].

Inquiry Team Member Role Description

As a volunteer Inquiry Team Member assisting the Student with this project, your role may include one providing advice on the relevance and wording of questions and letters of invitation to assist the Student and the BC Schizophrenia Society Victoria (BCSSV) in an organizational change process. In the course of this activity, you may be privy to confidential inquiry data, not including participants' names and positions on the BCSSV board. Your role will be to support the student with dialogues about the topic areas as needed, provide literature resources as needed, take notes during the focus group, answer questions and provide feedback regarding process and support the learning process for the student.

Confidentiality of Inquiry Data

In compliance with the Royal Roads University Research Ethics Policy, under which this inquiry project is being conducted, all personal identifiers and any other confidential information generated or accessed by the inquiry team member will only be used in the performance of the functions of this project. This information must not be disclosed to anyone other than persons authorized to receive it, both during the inquiry period and beyond it. Recorded information in all formats is covered by this agreement.

Bridging Student's Potential or Actual Ethical Conflict

You, as a neutral third party with no supervisory relationship with either the Student or potential participants, may be asked to work closely with the Student to bridge this potential or actual conflict of interest in this study. Such requests may include asking the Inquiry Team Advisor to: formalize the logistics for the data-gather method, and producing written transcripts of the interviews or focus groups with all personal identifiers removed before the transcripts are brought back to the Student for the data analysis phase of the study. As an Inquiry Team member you will not have access to participants' names, or other identifying information.

Inquiry Team members asked to take on third-party duties in this study will be under the direction of the Student and will be fully briefed by the Student as to how this process will work, including specific expectations, and the methods to be employed in conducting the elements of

the inquiry with the Student's direct reports, and will be given every support possible by the Student, except where such support would reveal the identities of the actual participants.

Personal information will be collected, recorded, corrected, accessed, altered, used, disclosed, retained, secured and destroyed by and as directed by, the Student, under direction of the Royal Roads Academic Supervisor.

Inquiry Team Members who are uncertain whether any information they may wish to share about the project they are working on is personal or confidential will verify this with Tara Timmers, the Student.

Statement of Informed Consent:

I have read and understand this agreement.

Name (please print): _____

Date: _____

Signature: _____

APPENDIX H: EXPERTS PROTOCOL & QUESTIONS (INTERVIEW)

Set Up

Before the start of the interview, I will put a do not disturb sign on the BCSSV group room door. I will check the recording equipment to make sure it works. I will have the interviewee's phone number, questions to ask and protocols sheet readily available. I will also have a copy of the interviewees signed consent form. Then, at the time the interview is to start I will call the long distance number of the interviewee to begin the interview. At no point during the research process will the participants be coerced to participate or deceived in any way.

Opening Commentary

Welcome (*name of participant*) to this interview for the purposes of gaining unique insights into how the BCSSV can develop a peer counselling program. I am a Masters in Leadership Health student at Royal Roads University completing a thesis requirement with the BCSSV.

Your time and participation is greatly appreciated. You have been chosen for this interview due to your expertise in the field of person in recovery from mental illness movement. Thank you for signing a consent/confidentiality form (*participant to email signed form if they have not already*).

You will be asked a series of questions that support dialogue on the topic of this action research project. Your answers will not be right or wrong. They will be your valuable insights into the topic. The session will last approximately an hour. You can choose to withdraw at any time. All your information will be kept confidential and recorded anonymously and you will be given an opportunity to look over the transcribed data for accuracy within one week of the interview.

This interview will be on speaker phone and will be digitally recorded, and I may make some notes to capture the details. You may ask that the digital recorder be turned off for a few minutes at any time during the interview, and then turned on again when you are ready. Are you ok with this? All data recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings.

The data collected from this interview will be analyzed for themes along with the other interviews I will conduct. As this research will also be published, a copy of this thesis will reside in the RRU library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/ UMI database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The data will be stored for the timeline of one year after approval of the final report by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After one year all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

I will ask you a series of questions one at a time with ample time between for discussion. Once a question has been explored thoroughly I will give you a brief summary of the discussion and move on to the next question. As this is a semi-structured approach other topics/questions on peer work may arise that we can also address. I am interested in hearing your stories and ideas on the topic area so will encourage you to share your thoughts.

The questions you will be asked in the interview are as follows:

1. In your experience through your work with the peer movement what are the current global and national trends in peer service development?
2. In your experience, what are your views of the recovery movement on the development of peer counselling programs?
3. How would human rights and social justice effect the development of a clinical peer counselling program?
4. What provincial or national standards are in place to support clinical peer practice in a healthcare setting?
5. If the BCSSV were to develop a peer counselling program what risks might they encounter?
6. Is there a body of research or similar programs being created from other jurisdictions that would support the development of a peer counselling program here in BC?
7. How would you argue the case for the development of a peer counselling program in regards to professional/clinical peer work?
8. In your opinion, what are the differences between peer support and peer counselling?
9. Is there anything else you would like to comment on that has not been mentioned, given the focus of this inquiry?

Closing

Upon completion of the interview the participant will be asked if they have anything else they would like to contribute before we close. The data will be transcribed within a week of the interview. At that point the participants will be reminded that they will have an opportunity to look over their own transcript. They will have 48 hours to look over their transcript and return it back to me. They can return it back to me by email at [email address] or by mail at [address].

APPENDIX I: BOARD PROTOCOL & QUESTIONS (INTERVIEW)

Set Up

Before the start of the interview, the room will be checked for a comfortable temperature, water or tea will be prepared, and the participants will be advised to seek a counsellor as needed. A blank consent form will also be on hand. Upon arrival the participant will be welcomed in the following way. At no point during the research process will the participants be coerced to participate or deceived in any way.

Opening Commentary

Welcome (*name of participant*) to this interview for the purposes of gaining unique insights into how the BCSSV can develop a peer counselling program. We know each other from our work at the BCSSV. I am a Masters in Leadership Health student at Royal Roads University completing a thesis requirement with the BCSSV.

Your time and participation is greatly appreciated. You have been chosen for this interview due to your personal insight, health system knowledge and expertise. Thank you for signing a consent/confidentiality form (*participant to sign form if they have not already*).

You will be asked a series of questions that support dialogue on the topic of this action research project. Your answers will not be right or wrong. They will be your valuable insights into the topic. The session will last approximately an hour. You can choose to withdraw at any time. All your information will be kept confidential and recorded anonymously and you will be given an opportunity to look over the transcribed data for accuracy within one weeks of the interview.

This interview will be digitally recorded and I may make some notes to guide the process. You may ask that the digital recorder be turned off for a few minutes at any time during the interview, and then turned on again when you are ready. Are you ok with this? All data recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings.

The data collected from this interview will be analyzed for themes along with the other interviews I will conduct. As this research will also be published, a copy of this thesis will reside in the RRU library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal, and the ProQuest/ UMI database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The

data will be stored for the timeline of one year after the final report has been approved by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After one year all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

I will ask you a series of questions one at a time with ample time between for discussion. Once a question has been explored thoroughly I will give you a brief summary of the discussion and move on to the next question. As this is a semi-structured approach other topics/questions on peer work may arise that we can also address. I am interested in hearing your stories and ideas on the topic area so will encourage you to share your thoughts.

The questions you will be asked in the interview are as follows:

1. What do you know about the risks and strengths of peer led services in mental health care in supporting clients?
2. Tell me about a time when you felt that the BCSSV was truly supporting its clients through peer resources. What was it about that time that made it so memorable to you? If you don't have a time in mind, what would you envision supportive peer service to look like?
3. If you were to imagine a future for BCSSV that included an extension of our peer support role, to include a new peer counselling program, what might this new program involve?
4. What do you see as the strengths of the current peer support program and how might these strengths be utilized as the BCSSV considers the possibility of a peer counselling program?
5. In your experience, are there any differences between these two programs that the BCSSV would need to keep in mind?
6. What would it take to successfully develop a clinical peer counselling position at the BCSSV.
7. What are your thoughts on disclosure of self-recovery from mental illness in a professional peer counselling role?

Closing

Upon completion of the interview the participant will be asked if they have anything else they would like to contribute before we close. I will follow up with the interview participant within 2 days to check on their well-being. The data will be transcribed within a week of the interview. At that point the participants will have an opportunity to look over their own transcript. They will have 48 hours to look over their transcript and return it back to me. They can return it back to me by email at [email address] or by mail at [address].

APPENDIX J: PROTOCOL & QUESTIONS (FOCUS GROUP)

Set Up

Before the start of the focus group, the room will be checked for a comfortable temperature, water or tea will be prepared, and a copy of the community counsellor's sheet will be on hand to be made available to the participants. The room chairs will be set up in a circular format with a table in the centre with a talking stick on it. There will also be two digital recorders to record the session. Blank consent forms will also be on hand. Upon arrival the participants will be welcomed in the following way. At no point during the research process will the participants be coerced to participate or deceived in any way.

Timeline for focus group of 80 minutes

Opening remarks/questions 10 minutes

Questions 7-8 minutes per question. Total 60 minutes

Closing remarks 10 minutes

Opening Commentary

Welcome to this focus group for the purposes of gaining unique insights into how the BCSSV can develop a peer counselling program. We know each other from our work at the BCSSV. I am a Masters in Leadership Health student at Royal Roads University completing a thesis requirement with the BCSSV.

The fellow inquiry team member who is assisting with note taking on flip charts will be introduced, and assurances given that she has signed a confidentiality agreement.

Your time and participation is greatly appreciated. Thank you for signing a consent/confidentiality form (*participant to sign form if they have not already*).

Thank you for expressing your interest in taking part in the focus group component of my research. Using qualitative action research methods, my goal is to develop recommendations to the BCSSV on the development of a peer counselling program. The information gathered from this focus group will be used in combination with other data gathered from interviews to produce a final report.

You will participate in a focus group with fellow volunteer board members from BCSSV, each of whom brings diverse backgrounds. I will be facilitating and arrangements have been made to ensure that this room remains private and free from interruptions for the time that we are here together. Your participation is completely voluntary and you will have the right to withdraw at any time. The focus group format will be fluid as long as only one person speaks at a time.

All data collected will be kept in my home in a secure place, on my password-protected computer and on a USB so that no external viewer can decipher the participants' identity. The

data will be stored for the timeline of one year after the approval of the final report by Royal Roads University in accordance with their guidelines. Once the digital recordings have been transcribed the recordings will be erased and deleted from the recording device. After one year all paper copies of transcribed data will be shredded. Continuing consent will be requested if the final thesis is used to launch future research projects.

Before we begin I will ask each of you to choose a pseudonym so as to support confidentiality. Each time you to contribute to the discussion please state your pseudonym first so that this anonymous identifier can be captured in the transcript.

You will be asked a series of questions that support dialogue on the topic of this action research project. Your answers will not be right or wrong. There is no need to control the direction of the conversation. Your thoughts and ideas will be valuable insights into the topic. The session will last approximately an hour and 20 minutes. You can choose to withdraw at any time. All your information will be kept confidential and you will be given an opportunity to look over the transcribed data for accuracy within one week of the focus group.

This focus group will be digitally recorded and flip charted notes will be taken by my fellow inquiry team member. Are each of you ok with this? I will inform the participants at this point that if they require the digital recorders to be turned off momentarily, they can let me know at any point during the focus group and can also ask that any notes taken on the flip charts be changed, added to, or deleted. All data recordings will be transcribed by an external transcriptionist who has signed a confidentiality agreement. The recorded data will be transferred to the transcriptionist directly from myself and no one else will have access to the recordings.

The data collected from this focus group will be analyzed for themes along with the other data I have collected. A copy of this thesis will reside in the Royal Roads University library as well as in Library and Archives Canada, accessed through the Thesis Canada Portal and the ProQuest/UMI database. The BCSSV will also be able to freely distribute copies of this document to external and internal community sources.

The questions that will frame the focus group session will be as follows:

1. What are the benefits of a peer counselling program for our organization?
2. What are the drawbacks or risks to a peer counselling program, in your opinion what are they?
3. In your experience what makes for successful peer led services and what advantages do they offer over professional counselling?
4. In your opinion, how can the BCSSV differentiate between Peer Counselling and Peer Support so as to not duplicate services?
5. Are you aware of any concerns, risks of challenges about the combination of peer work and professional practice that need to be considered?

6. What kinds of qualifications should a Peer Counsellor have? How does that differ from other peer programs?
7. What other programs that exist in Victoria BC are similar to Peer Counselling and what relevance might they have for BCSSV as it contemplates the possibility of moving in this program direction?
8. Is there anything else you'd like to share with me that I haven't asked you about?

Process

The focus group will be free flowing like a dialogue focused on the above questions. Silence will be honored and if needed myself as the facilitator will guide the participants on to the next question when the group seems to be finished with the last. The talking stick will be used by the person speaking and when they are done will place it back in the centre of the room for the next person. I will encourage quiet people to take a turn sharing their knowledge. If conflict or tension arises I will mediate it by stating that we are bound to come across some difference of opinions and I encourage everyone to keep learning and sharing in a respectful manner.

Closing

Upon completion of the focus group the participants will be asked how they feel about the process. They will be given a sheet of potential counsellors in the community as needed. They will be told I will follow up with them within 2 days to check on their well-being. When the data is transcribed they will be told they will have the opportunity to look over their comments to make sure what they said was captured accurately.

APPENDIX K: TRANSCRIPTIONIST CONFIDENTIALITY AGREEMENT

Privacy and Confidentiality

AGREEMENT

Between

Tara Timmers (Researcher)

and

(Name of Transcriptionist)

This agreement is part of a research thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF ARTS in LEADERSHIP- Health at Royal Roads University conducted with the approval of the Royal Roads University Research Ethics Boards.

As an individual providing transcriptionist support for this Research Project:

1. I understand that I am responsible for maintaining the privacy and confidentiality of all information I am exposed to from data collection sessions &/or data analyses.
2. I understand that I will have access to raw research data in a form that could be used to identify the individual(s) to whom it relates. I will not disclose any information to any other person and am bound by all terms and conditions of the present agreement.
3. Information and data collected and contained in the research records I create through transcription will not be used or disclosed for any purpose other than the prescribed project.
4. I understand that Tara Timmers (Researcher) is the sole owner of all data transcribed for this project.

Name

Signature

Date