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REVIEW ARTICLES

Peer support workers' role and expertise and interprofessional learning in mental health care: a scoping review

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ABSTRACT

Interprofessional learning (IPL), which is learning arising from the interaction between representatives of two or more professions, has not been studied extensively in relation to peer support workers (PSWs) in mental health care teams. PSWs support others who face challenges with their own experience of similar challenges of mental health problems. The role of PSWs has been studied in mental health care interprofessional teams. However, researchers have not paid attention to IPL where the PSWs contribute their knowledge. This paper is a scoping review that aims to highlight existing knowledge of the PSW role and expertise in IPL in the context of mental health care. The findings show knowledge of (a) the key factors and challenges when interprofessional teams include the PSW role, (b) the legitimacy of the PSWs' role and expertise, and (c) the benefits of the PSW role. A knowledge gap was identified of teams' use of PSWs' expertise and its implications for IPL.

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Scoping review; interprofessional learning; interprofessional teamwork; peer support worker; expertise

Introduction

During health care team work, interprofessional learning (IPL) can occur. IPL, which arises from the interaction between representatives of two or more professions (Freeth et al., 2005), can improve the quality of health care (Reeves, 2016). In health care, this learning is promoted by facilitating interaction where different expertise, perceptions, values, and experiences are exchanged, and jointly reflected by different professionals (Centre for the Advancement of Interprofessional Education, 2018). The prerequisite for this learning is interprofessional teamwork where the members "share a team identity and work closely together in an integrated and interdependent manner to solve problems and deliver services" (Reeves et al., 2010, p. xiv).

Research into IPL has not yet assessed teamwork where expertise of peer support workers (PSWs) is contributed. PSWs are employed to support others who face challenges with their own experience of similar challenges (Repper & Carter, 2010) of mental health illness (Cyr et al., 2016). The peer support approach assumes that people with similar experiences can offer better more authentic empathy and validation (Mead & MacNeil, 2006). In peer support, which can be informal, peers participate in consumer, or peer-run, programmes alongside formal mental health services, which may be statutory (Repper et al., 2013a). In health care services the PSWs' role is to focus on recovery (Asad, 2015; Gates & Akabas, 2007; Repper & Carter, 2010). Service users' needs are provided, for example, by helping them to think through concerns for coming appointments and how to convey these to the teams (Repper et al., 2013a). In teams, the PSW role is an adjunct to staff (Repper et al., 2013a). The PSW role was investigated in mental health care interprofessional teams (Asad, 2015). However, IPL was not observed in teamwork where PSWs contribute their expertise.

Instead, researchers have directed interest to educational activities. For example, to interprofessional clinical training in mental health and how this improves students' readiness for IPL and team collaboration (Marcussen et al., 2019) or to evaluations of Interprofessional Education (IPE) curricula highlighting how mental health settings become useful interprofessional learning experiences for students, trainees, and practitioners (Curran et al., 2012).

Background

The "expertise of lived experience" (Basset et al., 2010, p. 3) is of interest for IPL. In Swedish mental health care teams, PSWs were introduced having unique competence that "complement[s] established knowledge and professions" (Method manual, Nationell Samverkan för Psykisk Hälsa, 2018). PSWs' contributions become relevant for IPL, which is about learning among different health and/or social sector professions. Both IPL and peer support are based on the same assumptions that bringing together and exchanging different expertise raises the quality of care.

Researchers have shown how in care the patients' recovery has been facilitated by PSWs as role models who give support (Repper & Watson, 2012). PSWs drive forward a recovery-focused approach within a team where members' negative attitudes are challenged, leading to better understanding of patients (Repper et al., 2013a). Teams change their way of

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working and views after implementing peer support, and teams become more cost-effective by reducing patients' need for other interventions (Repper et al., 2013a).

Evaluations of the Swedish project that introduced PSWs, show how the health care staff developed a more recovery-based view on the patients' health (Wenzer, 2018). However, there have also been challenges, when staff perceived the PSWs' roles to be unclear (Collins et al., 2016; Repper & Carter, 2010) or when the staff did not respect the PSWs (Repper et al., 2013b). Lack of respect indicates challenges for PSWs contributing their experience and knowledge. In recovery oriented mental health care, PSWs are starting to be a common part of inpatient or community teams (Repper et al., 2013a) where the PSWs' role and expertise is of value to IPL. This learning deserves attention in teamwork where PSWs use their lived experience expertise to complement other professions that "draw on learned professional knowledge skills and expertise" (Repper et al., 2013b, p. 6).

This scoping review aims to highlight existing knowledge of the PSWs' role and expertise in IPL in the context of mental health care. The research question is: What do we know about the PSWs' role and expertise in the IPL field?

Method

Scoping review design

Arksey and O'Malley (2005) explained how scoping reviews aim to map main concepts within a research area and the sources and kind of evidence available, especially if the area has not been reviewed comprehensively before. According to Munn et al. (2018), scoping reviews can highlight the body of literature on a topic and contribute information of the amount of literature and its central concepts. We used a scoping review design by Arksey and O'Malley (2005) that has five stages. (a) Identifying the research question, (b) Identifying relevant studies, (c) Selecting studies, (d) Charting the data, and (e) Collating, summarizing, and reporting the results. The main value of conducting a scoping review is to comprehensively identify primary studies. Arksey and O'Malley recommended searching electronic databases, reference lists, and key journals.

Literature search strategy

The literature search was conducted in May 2021. These databases were used: CINAHL, ERIC, PubMed (via NCBI using MeSH), Medline, APA PsychInfo, Scopus, and Semantic Scholar (Table 1). The search was limited to peer reviewed English literature published between January 2000 and April 2021 due to the motive to seek modern research of PSW and IPL.

The search terms were determined by all the authors. Authors TV and JW conducted the literature searches and searched reference lists and seven key journals (*Mental Health Training, Practice and Education, International Journal of Mental Health Nursing, Irish Journal of Occupational Therapy, Social Work, Journal of Interprofessional Care, Journal of Mental Health, and Community Mental Health Journal*). UH and LN scrutinized the search results and the choices that were made. All authors were involved in the choice of the final studies in the review.

Inclusion criteria were identified in the beginning; exclusion criteria were determined after becoming more familiar with the literature, which is a recommended strategy in a scoping review (Arksey & O' Malley, 2005; Table 2). In the search process all four authors were engaged to enhance reliability, as inclusion of several reviewers can reduce errors and increase reliability (Peters et al., 2015). The PRISMA flow chart (see Figure 1) visualizes the study selection process.

A descriptive synthesis

A descriptive synthesis was conducted in four steps using Evans (2002) method. The first step was to gather articles or studies. The second step was to identify the key findings of each article. Key findings, which concerned the PSW role and expertise, were extracted from the results sections, discussions, and conclusions, and copied in a Word document. The key findings were extracted as paragraphs with quotations and manually coded by TV. The third step was to identify similarities and differences between the coded data to identify common themes. From these themes sub-themes were identified. The themes were scrutinized, revised, and renamed several times until final themes were determined. The fourth step was to describe each theme and refer to the original studies.

Findings

The review includes 22 qualitative studies and 1 quantitative study (Table 3, online supplement). Four themes with respective sub-themes were identified.

Theme 1: key factors of the PSW role in interprofessional teams

The theme presents some knowledge of the key factors of the PSW role in interprofessional teams. The sub-theme highlights key factors that affect the inclusion of a new role.

Sub-theme: ambiguity of role, disclosure of lived experience, professionalism and culture, stigma and hierarchy

Early on the inclusion of the PSWs' roles was *ambiguous* (Asad, 2015; Asad & Chreim, 2016; Burr et al., 2020; S. G. Gillard et al., 2013; Gillard, Edwards et al., 2014; Gillard, Holley et al., 2014; Nossek et al., 2021; Otte et al., 2020a), and it was unclear how PSWs should support consumers (Ehrlich et al., 2020). A team member said: "I don´t know exactly what their [PSWs] job description states . . . " (Ehrlich et al., 2020, p. 109). The PSW job posting was vague according to many PSWs (Asad, 2015; Asad & Chreim, 2016). One PSW thought that it indicated few requirements in addition to lived experience:

Table 1. Literature search strategy.

Search words/the number of records	
CINAHL Abstract, Peer reviewed, English. 200101-210430	Interprofessional or multidisciplinary or interdisciplinary or multiprofessional or team AND "peer support" AND "mental health" or psychiatry or "care management" or "community outreach" n: 88
ERIC All text, Peer reviewed, 200101-210430 English.	Interprofessional or multidisciplinary or interdisciplinary or multiprofessional or team AND "peer support" AND "mental health" or psychiatry or "care management" or "community outreach" n: 2
PubMed MeSH Terms, English. 200101-210430	(Interprofessional Education OR Interprofessional Relations OR Patient Care Team) AND (Peer Group) AND (Mental Health Services AND Patient Care Management) n: 70
All fields, English. 200101-210430	(interprofessional OR inter-professional OR "inter professional" OR multidisciplinary OR interdisciplinary OR multiprofessional or team) AND ("peer support") AND ("mental health" OR psychiatry or "care management" or "community outreach") n: 175
Medline Abstract, Peer reviewed, English. 200101-210430	Interprofessional or multidisciplinary or interdisciplinary or multiprofessional or team AND "peer support" AND "mental health" or psychiatry or "care management" or "community outreach" n: 103
APA PsychInfo Abstract, Peer reviewed, 200101-210430 English.	Interprofessional or multidisciplinary or interdisciplinary or multiprofessional or team AND "peer support" AND "mental health" or psychiatry or "care management" or "community outreach" n: 72
Scopus Article title, Abstract, Keywords. Date range: 2000–2021 English. Limits: Medicine, Nursing, Social sciences, Health professions	Interprofessional or multidisciplinary or interdisciplinary or multiprofessional or team AND "peer support" AND "mental health" or psychiatry or "care management" or "community outreach" n: 194
Semantic Scholar Limiters: 2000–2021 Fields of study: Medicine	Peer support workers or peer support providers in interprofessional mental health care teams n: 20 mental health professionals and peer support workers n: 20

> It [job posting] didn't say much, it said that you had to have experience with mental health and as a client, not necessarily as a provider. But that you were able to function okay, like take a full-time position … And pretty much be an advocate for the clients. It was very vague … (APS6; Asad, 2015, p. 35).

Table 2. Inclusion and exclusion criteria.

Inclusion criteria	Exclusion criteria
The literature that concerned PSWs, in the context of interprofessional learning/education, interprofessional team/teamwork/ work/collaboration/practice in mental health care.	The literature that concerned PSWs (a) that were community health workers (CHWs) because they do not necessarily have lived experience of mental illness, (b) that worked in hospital-based addiction-care.

However, the ambiguity of role also had positive aspects. According to Asad and Chreim (2016), Gillard, Edwards et al. (2014), and Nossek et al. (2021), the vagueness of the role also had a positive effect by giving more flexibility to define and shape the role.

Many researchers (Asad, 2015; Asad & Chreim, 2016; Cleary et al., 2018; Collins et al., 2016; Ehrlich et al., 2020; S. G. Gillard et al., 2013; Gillard, Edwards et al., 2014; Storm et al., 2020; White et al., 2017) also mentioned *disclosure of lived experience*. The disclosure required consideration of what and when to disclose information about themselves both to clients and to the team (Asad, 2015). Some team members expected PSWs to make disclosures (Asad, 2015; Ehrlich et al., 2020). Nevertheless, Asad (2015) showed some PSWs only shared relevant health information about clients to team members, due to the confidential relationship between the PSW and client.

It was also described how the PSWs, considering their disclosure of their past illness as important and advocating for patients' needs, also educated the team on alternative views:

> If in a meeting, it comes up that a client is not happy about taking medication … I can say I've experienced that and reflect it back to the team … You're advocating for the client and … educating the team (Asad & Chreim, 2016, p. 770).

Asad and Chreim (2016) discussed that disclosure is one important factor that influences the team's integration of the PSW role. The PSWs' sharing of personal information requires discretion when fitting with professional relationships (White et al., 2017) and maintaining clinical-based boundaries (Gillard, Edwards et al., 2014).

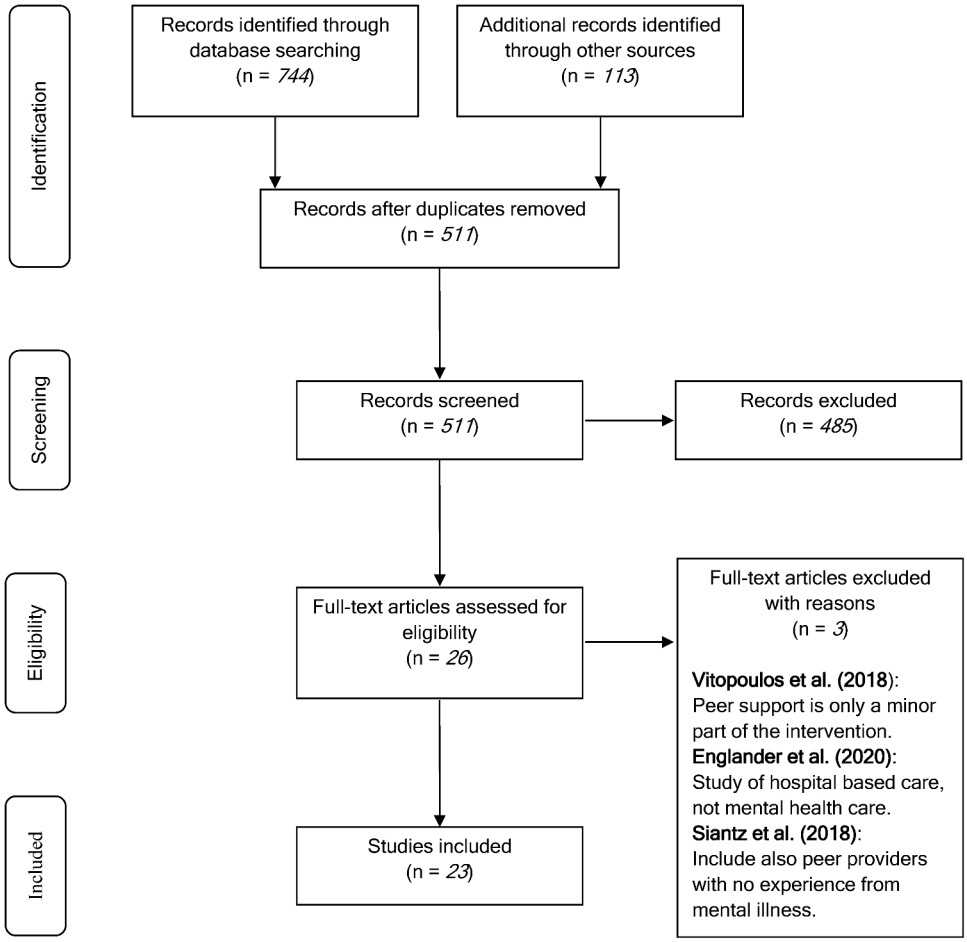

Figure 1. Preferred reporting items for systematic reviews and meta-analyses (PRISMA) flow diagram for the scoping review process (Moher et al., 2009).

Keeping to boundaries, especially in inpatient settings, was significant for the PSWs' *professionalism*. However, this professionalization as Gillard, Edwards et al. (2014) and Gillard, Holley et al. (2014) called it, risks blurring their role adapting to current culture. The inclusion of PSW then does not lead to change of *culture* that will be possible by challenging existing boundaries (Elias & Upton-Davis, 2015; Gillard, Edwards et al., 2014; Lloyd et al., 2017; Mulvale et al., 2019). Gillard, Edwards et al. (2014) discussed the importance of not reinforcing cultural norms by training PSWs to work within traditional hospital-based boundaries, as this makes it difficult for the sharing of lived experience to be valuable. Otte et al. (2020b) discussed how "the ability of PSWs to reflect on and articulate limits while staying true to their role as experts from experience seems to be a key point" (p. 293).

We also found how some PSWs, in the beginning when they talked about their role, identified *stigma* (Asad, 2015; Asad & Chreim, 2016; Burr et al., 2020; Collins et al., 2016; Elias & Upton-Davis, 2015; Gillard, Edwards et al., 2014; Gillard, Holley et al., 2014; Hensley & Dawson, 2017; Migdole et al., 2011; White et al., 2017). A PSW said: "There's definitely a stigma there that was experienced . . . I wasn't as comfortable in talking about my role . . . whereas now I'm quite comfortable about it and have gotten the confidence" (APS; Asad & Chreim, 2016, p. 770).

This exemplified how a PSW, by taking on more responsibilities, challenged the perceptions of stigma that then disappeared (Asad, 2015; Asad & Chreim, 2016).

The review also revealed how some PSWs experienced existence of a *hierarchy* in teams (Asad, 2015; Asad & Chreim, 2016; Burr et al., 2020; Cleary et al., 2018; Debyser et al., 2018; Ehrlich et al., 2020; S. G. Gillard et al., 2013; Gillard, Edwards et al., 2014; Mulvale et al., 2019). Hierarchical teams undermined the PSWs' interactions in meetings as equals. A PSW:

> Nurses and doctors hold a lot of power. And I'm sure there's a lot of transference that goes back to my days as a client. But I definitely feel at times . . . that their decision holds more weight than mine or I have less say in the care of a client because of my role. It can be frustrating, not feeling on the same level as another person on the team. It can be different, it can be alienating, it can be isolating at times (PS4; Asad, 2015, p. 49).

Ehrlich et al. (2020) showed how in the clinical teams the PSWs, acting as advocates for the consumers, needed to find their voice to be able to act against the clinically dominant ways of thinking.

Theme 2: challenges for the PSW role in interprofessional teams

The theme presents knowledge of the challenges for the PSW role in interprofessional teams. The sub-theme shows challenges in the inclusion of the PSW role in teams.

Sub-theme: a pioneer and expectations, patient or staff, workload and tasks, and complementary, but threatening role

Some researchers described how a PSW was *a pioneer*. This in turn was followed by certain *expectations* (Nossek et al., 2021; Otte et al., 2020a). Combined, these factors led to considerable pressure:

> The PSWs spoke about their fear of failure and illustrated how this feeling made it difficult for them to integrate into the multidisciplinary teams. They regarded themselves as pioneers, burdened with an immense pressure to succeed with no room for failure – otherwise they feared there would be no opportunity for other PSWs to be hired in the future (Otte et al., 2020a, p. 265).

Debyser et al. (2018) concluded from their study of nurses and PSWs' self-perceptions of their role-related competences, that both need encouragement to become more confident in themselves when evaluating their own achievements (p. 998).

Another observed challenge was whether the PSWs were perceived as *patients* or *staff*. Otte et al. (2020a) described how PSWs felt that they were being treated as patients rather than colleagues by the mental health professionals: "I feel like they observe me like a patient. They ask me numerous times 'Is everything okay? Are you okay?' They don't do this with the other team members." (PSW 2; Otte et al., 2020a, p. 265).

Collins et al. (2016) showed that a majority of psychiatrists were concerned that the PSW would become ill. Because this was perceived as a barrier against employing PSWs, this issue required careful consideration when implementing service user involvement. On the other hand, staff recognized the need for "not treating PSWs as patients" (IV9; Cleary et al., 2018, p. 1216) and thus challenged the "view that consumers cannot recover" (Elias & Upton-Davis, 2015, p. 307).

Some researchers acknowledged the PSWs' *workload* and *tasks*, for example, Ehrlich et al. (2020), described how the PSWs' role created support for the team in an everyday setting: " . . . running around trying to get things here and there, which from other office jobs that I've had that's usually been an administrative role to take care of that stuff " (PSW1; Ehrlich et al., 2020, p. 111).

PSWs ran the risk of ending up with an ever-expanding workload, but the full schedule could jeopardize their relationships with nurses (Nossek et al., 2021), who may already be stressed due to their own workload. The diversity of tasks; doing household chores, participating in meetings (Debyser et al., 2018), and too many generic tasks, due to being one in the team (Gillard, Edwards et al., 2014; Gillard, Holley et al., 2014) could also erode the distinctiveness of the role:

> I still do things because I am part of the team and if we are short staffed and things like that, if we have four patients on observations and we've got one staff member off sick . . . but sometimes it can have an impact on my role . . . if there are patients that really wanted one to one with me and I've not been able to do it . . . that is frustrating. NPW (Gillard, Edwards et al., 2014, pp. 70–71).

If there is a lack of common understanding of the central aspects of the PSW's role within the organization, this may be related to generic tasks, rather than to tasks that are distinctive to the peer workers role (Gillard, Edwards et al., 2014).

Our review highlights the PSWs *complementary role* (Ehrlich et al., 2020; Elias & Upton-Davis, 2015; Nossek et al., 2021; Otte et al., 2020b). It was reported that clinicians recognized that PSWs made valuable contributions (that did not require medical expertise), replacing some of the clinicians' work by, for example, accompanying consumers to their appointments:

> We also just knew that in some ways we didn't always need a clinician. We were able to identify that taking people to NGOs [non-government organisations], sometimes to their appointments didn't actually require a clinician (P004; Ehrlich et al., 2020, p. 110).

Another example of a complementary role was that PSWs also had, officially and formally, time to just talk to patients or perform other tasks that the mental health care professionals did not have time for (Otte et al., 2020b).

However, some researchers revealed how a PSW *role* could be *a threat* to other professions' role (Burr et al., 2020; Debyser et al., 2018; S. G. Gillard et al., 2013; Gillard, Edwards et al., 2014; Mulvale et al., 2019; Otte et al., 2020a; Simpson, 2013). Nurses were suspicious that they might be replaced by the PSWs (Gillard, Edwards et al., 2014; Otte et al., 2020a):

> PSW 9: There was this huge prejudice that I would replace them, especially nurses felt that way, like "What do they want?" A huge insecurity that was felt by many coworkers was that I am here to steal their jobs (Otte et al., 2020a, p. 265).

Burr et al. (2020) also discussed how one of the most common challenges was that PSWs "may pose a threat to the staff's roles" (p. 219) in Switzerland. Simpson (2013) explained that, in the United Kingdom a growing presence of less expensive PSWs have replaced job openings for nurses.

Theme 3: legitimacy of the PSW role and expertise

The theme presents knowledge of the legitimization of the PSW role and expertise. The sub-theme shows the factors that contribute to legitimize the PSW role and expertise.

Sub-theme: becoming a legitimate member, the expertise, training and supervision/support, certification and remuneration

The teams eventually included the role of the PSWs that thus *became a legitimate member* (Asad, 2015; Asad & Chreim, 2016; Ehrlich et al., 2020). With more interactions team members started to understand and appreciate the PSW role (Asad & Chreim, 2016). As a PSW reported:

> But most of the team members will acknowledge the value that talking to someone who's been there is extremely valuable. I'd like to think that there are times that I keep the team in check . . . I keep it from a very empathetic standpoint (PS4; Asad, 2015, p. 50).

Team members accepted the PSWs due to their strengths and skills (Ehrlich et al., 2020). By providing psycho-social support that responded to consumers' needs as individuals, the PSW could fit with the staff's biomedical understanding within a clinical team. By managing to "fit" with various perspectives, the PSW became a legitimate member of an interprofessional team (Ehrlich et al., 2020). Teams "appreciated the PSWs statements" (Nossek et al., 2021) and that there was no evidence that shows resistance "to view service users as experts" (Collins et al., 2016, p. 282).

The PSWs' *expertise* was explained in different ways. Most of the studies referred to expertise as advocates (Asad, 2015; Asad & Chreim, 2016; Cleary et al., 2018; Ehrlich et al., 2020; Elias & Upton-Davis, 2015; Mulvale et al., 2019; Storm et al., 2020) "that bring in the patients' perspective" (Nossek et al., 2021, p. 592) or "mobilize clients toward advocacy" (Hensley & Dawson, 2017, p. 143). Storm et al. (2020) exemplified how advocacy is of value in interprofessional meetings. A case manager said: "I had a team meeting the other week because I had a client who just was upset about something her therapist had done. And the peer support person was there to add her insight" (p. 3). Other descriptions of PSWs' expertise were being a "source of information (about patients' rights)" (Asad & Chreim, 2016, p. 770) or having patients' rights as a focus (Asad, 2015). The lived expertise was tacit and experiential, which was explained by a PSWs as "just knowing what it feels like to take medication" (Oborn et al., 2019, p. 1314). The experiential knowledge complemented staffs' formal expertise through socialization in mental health care, subjective expertise, and "non-traditional expertise" (Gillard, Edwards et al., 2014, p. 106).

However, some researchers problematized the PSWs' lived expertise as being their only knowledge base. For example, mental health registered nurses thought that PSWs used their lived experience to "justify their role" (Cleary et al., 2018, p. 1215). Collins et al. (2016) pointed to how PSWs sometimes "can only see things from their own perspective" (p. 282). One PSW also acknowledged that this was a problem: PSW 6: "What I struggle with is the lack of knowledge when it comes to other illnesses . . . " (Otte et al., 2020a, p. 265).

The majority of the researchers identified the importance of *training* (Asad, 2015; Asad & Chreim, 2016; Burr et al., 2020; Debyser et al., 2018; Ehrlich et al., 2020; Elias & Upton-Davis, 2015; S. G. Gillard et al., 2013; Gillard, Edwards et al., 2014; Gillard, Holley et al., 2014; Mulvale et al., 2019; Otte et al., 2020a; Simpson, 2013) for the PSWs. The PSWs' lived expertise was described as important, but insufficient to be able to work in interprofessional teams. Instead:

> [PSWs] . . . actually have to have skills, you have to have a good understanding and recovery, you´ve got to have skills and training behind it as well. You can´t just be placed out and go "here you go, you've got lived experience, there you go." It´s not like that (P006; Ehrlich et al., 2020, p. 109).

Researchers recommended that organizations that prepare and train staff about peer support underscore the value of the role (Asad, 2015; Mulvale et al., 2019; Simpson, 2013), and develop and implement guidelines (Burr et al., 2020). Otte et al. (2020a) suggested more research on training, which should be offered for teams, including the PSWs.

Supervision (Debyser et al., 2018; Elias & Upton-Davis, 2015; S. G. Gillard et al., 2013; Gillard, Edwards et al., 2014; Gillard, Holley et al., 2014; Hensley & Dawson, 2017; Lloyd et al., 2017; Migdole et al., 2011) and *support* (Asad, 2015; Debyser et al., 2018; Lloyd et al., 2017; Nossek et al., 2021), which were also considered important for the PSWs, were not always offered (S. G. Gillard et al., 2013). S. G. Gillard et al. (2013) concluded that in mental health services there is often lack of support that is important to bring the PSWs' "distinctiveness to the team" (p. 11).

Some researchers considered different aspects of *certification* that represents knowledge/education (Asad, 2015; Gillard, Edwards et al., 2014; Gillard, Holley et al., 2014; Mulvale et al., 2019; Storm et al., 2020). Asad (2015) reported that many PSWs were positive about certification as this could make others recognize peer support as a real occupation. A PSW said:

> It adds accountability, a standard of practice. All the things that go into making peer support a real profession. Because right now we're kind of trying to find our way. Certification is gonna go a long way into making this an actual discipline where people can study it in school, and where it's recognized as a real profession. It's a career (PS4; Asad, 2015, p. 75).

Certification seemed to be relevant for the legitimacy of the role of the PSWs in mental health care centers, given that they all were certified (Storm et al., 2020).

A few PSWs wanted more research about certification, which also, as one PSW said, could be in conflict with the idea of grassroots, a user-led ethos, that peer support is part of: "Until there's more known about it . . . I don't know . . . I always have a little streak in me that's a little bit concerned about codifying or normalizing or enshrining peer support, because it is grassroots as well . . . " (PS1; Asad, 2015, p. 75). Gillard, Holley et al. (2014), who also called for more research, discussed whether the solution was to establish a quasi-professional content-based practice that gives authority at a national system-level or a less strict, value-based approach that ensures the PSW role is provided with the essential qualities.

The review also demonstrated the significance of *remuneration* (Burr et al., 2020; Collins et al., 2016; Gillard, Edwards et al., 2014; Migdole et al., 2011; Mulvale et al., 2019; Nossek et al., 2021; Otte et al., 2020a) that also seemed to be important

when recognizing a PSW's contribution (Asad, 2015; Asad & Chreim, 2016; Storm et al., 2020). Some PSWs thought that remuneration correlates with legitimacy but also tokenism on the team:

> If you're paid less than the other professionals, you don't have legitimacy. If you're coming in and saying, "I have my own mental health issue" and you're getting paid less, you don't have much clout on that team . . . If I had been paid significantly less, it would just have been a token position . . . There would have been no credibility, no legitimacy, nothing. But I'm paid on par with the others (APS8; Asad, 2015, p. 51).

Asad and Chreim (2016) suggested remuneration could be used for judgment of, for example, the value of one's role: "Remuneration can be used to identify the level of education and expertise required . . . and/or be indicative of the value of one's role on the team" (p. 771).

The review also revealed how the PSWs' payment differs and has consequences for the continuity of peer support in teams. Storm et al. (2020) described how in some clinical teams PSWs, who are hired by community mental health centers, are provided with insurance and paid time off, whereas other PSWs are funded through grants. Mulvale et al. (2019) called for more funding, to offer PSWs more stable full-time positions.

Theme 4: benefits of the PSW role

The theme presents knowledge of the benefits of the PSW role. A sub-theme shows the PSWs' beneficial function and contributions to individuals and teams/different professions.

Sub-theme: role model and guidance and support, PSW´s contributions, bridge, collaboration with PSWs, and peer programs and IPL

A PSW could be considered as a *role model*. Several researchers (Cleary et al., 2018; Collins et al., 2016; Ehrlich et al., 2020; Elias & Upton-Davis, 2015; Gillard et al., 2013; Gillard, Edwards et al., 2014; Mulvale et al., 2019; Nossek et al., 2021; Oborn et al., 2019; Otte et al., 2020b) described how a PSW as a role model may give individuals hope of recovery. PSWs are "instilling hope, acting as role models" (Collins et al., 2016, p. 281).

We found examples of PSWs' *guidance and support to individuals* (Cleary et al., 2018; Collins et al., 2016; Storm et al., 2020). One example concerned individuals with several mental illness (SMI; Storm et al., 2020). They showed how, in community health centers, PSWs talk about how to navigate the mental health, social, and primary care service systems, when leading support groups. A division director said:

> We have what's called a Life enrichment center, which is a peer-run center here in this office, that has peer support group offerings. They talk a lot about advocacy and social justice and navigating the system. They talk a lot about alternatives to the traditional medical model of mental health treatment (Storm et al., 2020, p. 4).

PSWs also helped individuals by preparing them for physical and mental health care visits (Storm et al., 2020). The PSWs facilitated the coordination of physical and mental health services. Another example of guidance and support was PSWs using their lived experience to facilitate consumer decision-making (Cleary et al., 2018).

The review also highlighted benefits for the mental health professionals through the PSWs' *contributions of experiences, knowledge, and perspectives*. Otte et al. (2020b) described how in teams the PSWs gathered different knowledge about patients, knowledge that may not be conveyed to the other team members:

> PSW 4 (interview): Sometimes, in our multi-professional meetings, we find out that I know very different things about the patients than my colleagues do. For example, we had a patient who confessed her drug abuse to me, which she has not told her treating physician and therapist yet. I told her that it would be important for them to know this . . . She said that she was very afraid to tell them but that it would be okay for her if I would tell them . . .. (Otte et al., 2020b, p. 291).

Nossek et al. (2021) showed different professionals understood "the specific skills and knowledge of PSWs and were inclined to use the PSWs' special expertise for the benefit of the patients" (p. 594), for example, developing recovery groups. S. G. Gillard et al. (2013) reported PSWs' additional skills and resources enriched the team's mix of skills, by providing fresh insights and knowledge. The differential knowledge could "guide professionals . . . professionals can't really see from the point of view of the service user . . . " NST (Gillard, Edwards et al., 2014, p. 67).

PSWs reported their experiences could be helpful for other mental health professionals, regarding how to approach a patient in a psychotic state (Otte et al., 2020b). The PSWs' perspectives could serve as a corrective to the mental health professionals' perspectives: "the PSWs gave me feedback directly on how they experienced the situation, how they viewed my routine . . . To me, this was an important add-on and a perspective . . . " (MHP 17; focus group; Otte et al., 2020b, pp. 291–292).

Many researchers noticed that PSWs function as *a bridge* (Debyser et al., 2018; Ehrlich et al., 2020; Gillard, Edwards et al., 2014; Migdole et al., 2011; Mulvale et al., 2019; Nossek et al., 2021; Oborn et al., 2019; Otte et al., 2020b; White et al., 2017). Otte et al. (2020b) described how mental health care professionals considered PSWs as a bridge, helping professionals and caretakers alike to gain insights: (MHP 24; focus group): "A bridge between the patients and us with a chance for a better understanding of each other . . . " (p. 292).

Ehrlich et al. (2020) demonstrated how, by developing relationships with the team members, consumers, and within the organization, PSWs became a bridge supporting integration of the individual across a fragmented care system. The PSWs could "bring a unique dimension to clinical care that enhanced the team's response to individual consumer needs" (Ehrlich et al., p. 111). The PSWs could build trust-based pathways for clinicians and team members to implement clinical care. These trust-based pathways made transition of consumers between different places of care less fragmented.

The review highlighted beneficial aspects of mental health care professionals' *collaboration with PSWs*. Some researchers emphasized the need of collaboration between PSWs and occupational therapists (Lloyd et al., 2017) and social workers

(Hensley & Dawson, 2017), as collaboration "can help ensure a multifaceted approach to mental health care" (p. 144). Nurses and PSWs need to collaborate because it can improve recovery-oriented care (Cleary et al., 2018; Debyser et al., 2018; Simpson, 2013) with "focus on [service-users] recovery and strengths, not just symptoms, deficits, and illness" (Simpson, 2013, p. 4).

However, building such partnerships requires attention to potential barriers, for example, when mental health registered nurses perceived PSWs' compromise of boundaries problematic (Cleary et al., 2018), or when nurses' distinct roles were not acknowledged and recognized (Debyser et al., 2018). Such tensions made it difficult to work "towards a collaborative practice in which they are supported to explore and learn from each other" (Debyser et al., 2018, p. 999).

The review revealed various aspects of the development of *peer programs and interprofessional learning* (Elias & Upton-Davis, 2015; Migdole et al., 2011; Weller et al., 2021). Elias and Upton-Davis (2015) indirectly informed the IPL potential in a peer program where a social workers knowledge and values were utilized. Social work, based on principles of social justice, in preventing stigma and marginalization, was a valuable addition developing a peer-based program in an inpatient psychiatric service. Due to consumers' difficulties managing the power relations and a complex hospital environment, the program was assumed to benefit from a social workers' contributions to support program development because of its critical role in a team.

Migdole et al. (2011), who described a development of a peer-based patient support program for a hospital's Emergency Department psychiatric service, also indirectly exemplified IPL potential. The program's central goal was to train and employ consumers of the mental health system. The recruits were then to function as PSWs assisting other consumers dealing with the environment of the crisis intervention unit (CIU), located in the general ED. One contribution (and a possible example of IPL) from the PSWs was when they shared their experiences in "the education of the medical students during their emergency room rotation" (p. 10).

Weller et al. (2021) presented development of a workforce development program: the Interprofessional Peer Education and Evidence for Recovery program (I-PEER). This program, which trained master's students in social work and occupational therapy to better serve persons with mental health conditions and substance use disorders, focused on services for adolescents and adults in rural behavioral health settings and integrated PSWs. The PSWs and students collaborated and interacted in activities that promoted IPL. I-PEER was recommended to train "students, peer support workers and providers on empirically supported treatments and evidence informed practices that address opioid misuse and corresponding mental health conditions" (p. 226).

Discussion

This review highlighted knowledge of the PSWs' role and expertise in IPL. The findings show key factors and challenges when the PSW role is included in interprofessional teams, the legitimacy of the PSW role and expertise, and the benefits of the PSW role.

Many of the studies investigated or highlighted key factors and/or challenges when a PSW role was included in interprofessional teams. In teams, the *ambiguous role, disclosure of lived experiences*, and *professionalism and culture* were, due to their interrelated dependence, examples of important factors for a successful inclusion of the PSW role.

The PSW's *ambiguous role* was described as both positive and negative. The studies highlighted in the beginning the unclear role of the PSWs (Asad, 2015; Asad & Chreim, 2016; Ehrlich et al., 2020) in alignment with previous research (Repper et al., 2013b). Researchers emphasized that teams, when planning to include PSWs, early on used to discuss the different kinds of expertise and roles (Repper et al., 2013b) and define these (Asad, 2015). However, the ambiguous role could offer more flexibility to PSWs to shape their role and work (Asad, 2015; Asad & Chreim, 2016).

Disclosure of lived experience was interconnected with *professionalism and culture*. PSWs were required to contemplate what and in which situations disclosure to team members and/or clients was appropriate (Asad, 2015). Professionalism was strongly related to the maintenance of clinical boundaries, something Gillard, Edwards et al. (2014) found problematic as it runs the risk of diluting the PSW's role, and further adapting to prevailing culture. Therefore, it was underscored that setting of boundaries should be reflected in training and supervision (Otte et al., 2020a).

One challenge was that the PSWs' *threatening role*, for other professions, may be due to being a *complementary* role. When PSWs accompanied consumers to their appointments (Ehrlich et al., 2020), PSWs could become an asset to other practitioners as the others do not need to engage in support that does not need their specialist professional expertise (Repper et al., 2013b). This way the staff's roles were complemented by the role of the PSWs. However, the PSWs could also be perceived as a threat to other professions' roles (Mulvale et al., 2019), such as nurses (Simpson, 2013).

Some factors legitimized the PSW's role and expertise. As time passed the teams started to accept the PSWs who *became a legitimate member* (Asad, 2015; Asad & Chreim, 2016; Ehrlich et al., 2020). Ehrlich et al. (2020) found that taking a place as a legitimate member of the interprofessional team was possible when the PSWs, by adapting in the team and the clinical structure and consumers' needs, could also adapt with multiple different perspectives.

The staff's biomedical perspective was complemented by the PSWs' psycho-social perspective with an individualistic focus on the consumers' needs (Ehrlich et al., 2020). The use of the PSWs' recognition of consumers' individual strengths provided a more holistic view of the patients' care (Mead et al., 2001). The PSW's psycho-social support, combined with the staff's biomedical perspective, could lead to more individually focused care.

The PSWs had *expertise* as advocates (Mulvale et al., 2019), conveying the patient's insight in interprofessional meetings (Storm et al., 2020). In teams the PSWs' experiential knowledge was useful and added to the other professions' formal expertise (Oborn et al., 2019). Their lived expertise was tacit and experiential, consistent with "expertise of lived experience" (Basset et al., 2010, p. 3) used to represent patient's needs.

We also found different opinions about *certification*. It was considered important for the legitimacy of the PSW role (Asad, 2015; Mulvale et al., 2019; Storm et al., 2020). However, an alternative to certification, because it can threaten the peer support grass-roots ideal (Asad, 2015), may be to establish an informal, values-based approach based on the core qualities that underpin the PSW role (Gillard, Holley et al., 2014).

Ehrlich et al. (2020) exemplified how PSWs, by building relationships within and outside the team and organization, became a *bridge* that supported and integrated the individual across a specialized care system. The review confirmed how in care the PSWs can offer a "truly comprehensive and integrated model of care" (Repper et al., 2013b, p. 1).

We shed light on the benefits when different professions *collaborate with PSWs*. Nurses (Cleary et al., 2018; Debyser et al., 2018; Simpson, 2013), occupational therapists (Lloyd et al., 2017), and social workers (Hensley & Dawson, 2017) can by collaborating with PSWs improve recovery-focused care. In care collaborations can lead to exchange of knowledge among different professions and PSWs (Debyser et al., 2018).

A few researchers also presented development of *peer programs* and *interprofessional learning*. Elias and Upton-Davis (2015) described how knowledge from a social worker benefited developing a recovery-based peer program, and indirectly illustrated IPL potential. Migdole et al. (2011) also indicated how in professional peer teams IPL could occur between medical students and PSWs when they shared their lived experience with a purpose to educate. Weller et al. (2021) explicitly facilitated IPL in a workforce development program where students from occupational therapy, social workers, and PSWs participated.

A knowledge gap – the consequences for IPL in teamwork with PSWs

This review identified a need for new research on teams' use of PSWs' and the implications for IPL in teamwork. In teamwork the recovery-focused PSWs are "working together or co-producing alongside traditional mental health care professionals" (Repper et al., 2013b, p. 1). We found examples of learning in interprofessional teams: how in teams staff can be educated by the PSWs who present alternative views (Asad & Chreim, 2016), convey perspectives that change the professionals' perspectives (Otte et al., 2020b), contribute "a unique dimension to clinical care that enhances the team's response to individual consumer needs" (Ehrlich et al., 2020, p. 111), "guide professionals" (Gillard, Edwards et al., 2014, p. 67), and contribute "fresh insight and knowledge to the whole team enriching the team's skills mix" (S. G. Gillard et al., 2013, p. 9). Ehrlich et al. (2020) described how interprofessional teams, despite hierarchical structures, can, by acknowledging the PSWs' strengths and skills, acknowledge their legitimacy as a team member. Being appreciated for their skill set, and breaking boundaries rather than fitting in with existing culture can change the culture (Gillard, Edwards et al., 2014). In mental health care PSWs with lived expertise, which is shared with the other professions, make IPL in teamwork relevant to study.

This review contributed insights into the implicit IPL potential in teamwork where different professions interact with PSWs. We did not find *any* research study of IPL in teamwork, thereby identifying a knowledge gap regarding the teams' use of PSW expertise and the consequences for IPL in teamwork.

Limitations

The review, which followed Tong et al.'s (2012) guidelines on transparency (the ENTREQ Statement), has several limitations. One limitation was the decision to exclude gray literature. This was decided as the initial search (websites, policy documents, etc.) led to a marginal addition. Another limitation is that the analysis may lead to overlapping themes, because of the intention to provide a detailed description of the research area. A further limitation is that some relevant articles may have been missed, despite a comprehensive search process.

Conclusion

We showed research on the PSW's role and expertise in IPL, in the context of mental health care, and what research is desirable in IPL including knowledge of important factors and challenges when PSWs take part in interprofessional teams, the legitimacy of the PSW role and expertise, and PSWs' beneficial function and contributions for recovery-oriented care. In light of current knowledge in IPL, this review calls for research into how IPL is affected in teamwork with PSWs.

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