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Rapid realist review of organisational supports for youth peer support workers

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ABSTRACT

Objectives Providing peer support can benefit youth peer support workers (peers)et by supporting self-determination, recovery and resilience to self-stigma. There is a need to clarify the role of the organisation in providing benefits for peers. We aimed to identify the organisational contexts and mechanisms that result in the creation of healthy workplaces for peers.
Design Rapid realist review guided by the Realist and Meta-Narrative Evidence Syntheses–Evolving Standards guidelines and Pawson's iterative approach.
Data sources MEDLINE, CINAHL, PsycINFO, ERIC, SocINDEX, Google Scholar and Embase were searched from 1979 to 2025.
Eligibility criteria We included qualitative and quantitative peer-reviewed studies and grey literature that captured characteristics of organisational practices and employment considerations in youth peer support programmes.
Data extraction and synthesis Articles were screened independently by multiple reviewers. Inclusion criteria were adjusted to capture literature on organisational practices, and employment considerations for youth peer support programmes. Data were extracted and analysed retroductively to develop Context-Mechanism-Outcome Configurations (CMOCs).
Results Five employment-related risks to peer well-being were identified: (1) difficulty entering the job market, (2) lack of role clarity, (3) pressure to live up to ideals, (4) retraumatisation and (5) stigma. Six CMOCs were developed; all focused on the creation of equitable employment and supporting peer development and empowerment were developed.
Conclusions Community-based mental health organisations can facilitate equitable peer employment through strategies that reduce professional stigma, enhance peer resilience and promote professional and personal development. Policy reform that addresses precarious work conditions is needed to support healthy work environments.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The review follows the Realist and Meta-Narrative Evidence Syntheses–Evolving Standards standards and Pawson's iterative approach to realist reviews.
⇒ A comprehensive search strategy enabled an inclusive examination of available literature.
⇒ Inclusion of a grey literature search ensured that findings were relevant to the field.
⇒ The involvement of peers ensured findings were grounded in lived experience.
⇒ Some relevant literature may be missed due to the rapid nature of the review.

INTRODUCTION/BACKGROUND

Peer support is broadly defined as a supportive relationship between two or more individuals who share a similar lived experience.[1] Within the youth mental health service system, formal peer support programmes are defined as structured services provided by trained peer support workers with lived mental health experience, offering one-on-one or group support to youth aged 12–25 seeking help for mental health concerns, with training ensuring safety, consistency and equity in service delivery.[2] Peer support offers a non-judgemental, accessible complement to traditional health services and has been increasingly integrated into care models.[3–5] While current literature focuses on the role of peer support in improving outcomes of mental health service users, there is a growing body of evidence pointing to the benefit of peer support practices for the youth peer support workers (peers) themselves.[3 6–8] As peer support continues to be integrated into youth mental health services, there is a need to increase the evidence regarding existing workplace conditions for peers and identify how to maximise benefits to both service users and the peers themselves.

Youth peer support in Canada is primarily delivered through formal mental health and substance use services (eg, hospital), community-based organisations (eg, community centres) and Integrated Youth Service hubs.[1–3 9–12] Programmes often include group sessions, one-on-one support, social

and recreational activities, navigation assistance and outreach, with some incorporating culturally specific approaches like Indigenous healing.[13] Organisations tend to employ peers as paid staff; however, a number continue to rely on volunteers or provide stipends.[13] Corrigan *et al*[14] outline three distinct pathways whereby stigma can impact individuals coping with mental health issues. Public or social stigma relates to the process whereby stereotypes regarding individuals with mental health issues are widely held across a society.[14] Self-stigma involves the internalisation of social stigma by individuals with mental health issues, resulting in the loss of self-esteem. Structural stigma describes institutional policies and practices that systematically limit opportunities for individuals with mental health issues. Peer support practice has been associated with several benefits to peers, including increased self-esteem/efficacy and reduced self-stigma.[15 16] An evaluation of a youth peer support programme found that peers developed stronger self-determination, resilience to stigma and overall recovery through their work.[3] Supervision has been identified as an integral component of positive organisational environments for peers.[15–17] Effective supervision—characterised by emotional support and understanding the peer role—has been reported to mitigate job-related stress, enhance self-esteem[18] and support professional development.[8 15 17] There is an ongoing need to clarify the role that the organisation can play in contributing to the benefits felt by peers.

Over the past decade, a body of research has emerged documenting the potential risks that peers may be exposed to through their work within the traditional mental health service system.[5 9 16 17] Despite advances in the field, there is broad agreement that the peer role is poorly defined.[9–11 19–22] Role ambiguity can create significant challenges for peers,[10 11 19 22] undermining collaboration and team functioning,[5 16–18 20] contributing to role drift and leading to stress and challenges as peers navigate boundary-setting with the clients they serve.[9 19 20]

Mechanisms of influence operating on peers within their work are complex and appear to have divergent influences. For example, peer support has been identified as a promising practice to mitigate stigma related to mental health issues for peers and clients. Possible mechanisms by which this occurs include the normalisation of experiencing mental health issues[3 16–18 23] and the recognition of the value of lived experience.[3 16 18 23] However, peers also continue to be stigmatised within their work environments.[3 18–20 22] This may be related to ongoing negative public perceptions of mental health and substance use issues,[24 25] as well as peers' lack of formal clinical/medical training.[19] Self-stigma may be related to colleagues' perceptions and a heightened pressure for peers to represent themselves as being fully recovered/in optimal mental health.[9 17] Identifying the characteristics of organisational contexts that can mitigate stigma experienced by peers requires further study.

Theory underpinning peer support

There is a diverse range of theoretical research that has been applied to examine peer support practice. For example, the Social Cognitive Theory[26 27] has often been used to explain how peer support functions. In particular, several related concepts are useful in describing the processes that may be most influential within peer support practice, including self-efficacy and observational learning through social modelling.[12 23 28–30] Another key benefit offered within peer support is the opportunity for clients to practise social skills and develop healthy social relationships,[15 31] and these processes align with the Bioecological Model[32] as well as the Self-Determination Theory.[23] Finally, the concepts of autonomy and empowerment are strongly implicated in peer support practice and again supported by Self-Determination Theory.[6 23] Another relevant conceptual framework that was developed to better understand recovery within mental health is the CHIME framework.[33] This model delineates connectedness, hope/optimism, identity, meaning and empowerment as key elements of the recovery process. This framework has been applied to better understand how peer support functions and more recently has been used to explore the benefits of youth peer support.[34]

In contrast, the use of theory to explain how youth peer support can result in positive outcomes among peers is limited. Delman and Klodnick[18] used a framework based on social capital theory[35 36] to identify factors facilitating the success of young adult peer providers in community mental health settings, including confidence, training, appropriate supervision and support from colleagues, while Halsall *et al*[3] examined peer-related outcomes using the Bioecological Model.[32] They highlight the reciprocal interactions that are set in motion through finding stable employment and how accessing a career path facilitates healthy outcomes longitudinally through adulthood. These considerations align with several elements of the Bioecological Model, in that supportive interactions (proximal processes) within a healthy work environment (context) facilitate professional growth and independence over the long term (time).[32] Additional research is needed to understand the theoretical underpinnings of outcomes for individual peers.

Realist methodology

Due to the inherent complexity of implementing youth peer support within more traditional organisational contexts,[37–39] a realist approach to evidence synthesis was conducted. This theory-driven approach seeks to explain programme outcomes by analysing literature from a variety of sources to develop context (C) mechanism (M) outcome (O) configurations (CMOCs).[38 40 41] Within these causal chains, 'context' represents provider, client or environmental characteristics or cultural or social norms that are critical to programme functioning. 'Mechanism' signifies the causal relationship mediating the generation of programme benefits.[42] The 'outcome' of a CMOC represents the positive impacts related to

programme functioning. The flexible and iterative nature of traditional realist reviews can be time-consuming[39 41 43]; rapid realist reviews combine the core elements of traditional realist review methodology with the inclusion and exclusion criteria of scoping reviews.[38]

Review purpose

A comprehensive understanding of the underlying mechanisms driving effective and appropriate support for a youth peer workforce within child and youth mental health (CYMH) services is needed to bring about organisational-level changes (systemic changes to workplace operations and culture). Decent work is defined as working conditions aligned with the social determinants of health, and therefore offers fair pay, adequate benefits and physically/psychologically safe workplace conditions.[44 45] This rapid realist review aimed to address the above gaps and synthesise the evidence on youth peer support programmes for mental health concerns in community-based CYMH services to better understand how to facilitate the development of organisational contexts to support the creation of decent employment opportunities for peers. The results of this review will guide development of recommendations for youth-serving organisations that support and promote peer employment.

The overarching question for this review was developed collaboratively with AD (executive director of Peer Support Canada): What is the emerging evidence with respect to how organisations can prepare, support and sustain healthy employment contexts for peers within CYMH services? Specific guiding questions were: (1) What are the underlying contexts, mechanisms and outcomes that are implicated in developing healthy youth peer support work environments? and (2) What is required to implement the organisational changes needed to create a healthy work environment for youth peer support roles in youth-serving, community-based mental health service settings?

METHODS

Definitions

Formal programmes were defined as structured programmes delivered by trained peers.[2] Youth peer support workers (peers) were defined as individuals meeting our stated definition of youth (see introduction) and providing mental health support for near-age individuals. Community-based organisations were defined as services offered outside of a traditional medical environment (eg, a structured environment where a licensed professional provides one-on-one care like a clinic[46]). As effective youth-friendly mental health services must address a wide spectrum of needs, including substance use, emotional distress and holistic wellness to support youth engagement and improve outcomes,[47 48] mental health was defined broadly to include all possible services. Post-secondary institutions were included due to their similar approaches to community-based youth mental health services, including embedding accessible, stigma-reducing mental health services within familiar environments and partnering with other organisations to provide holistic, culturally responsive care for students.[49 50]

Search strategy and selection criteria

This review was conducted according to the Realist and Meta-Narrative Evidence Syntheses–Evolving Standards[51] and Pawson's (2006)[41] iterative process for realist review. An initial exploratory search (online supplemental resource 1) was conducted in February 2024 to identify the scope of the literature, test inclusion/exclusion criteria and identify grey literature documents. Medline, CINAHL and Google Scholar were searched. Google Scholar was searched using the terms: "peer support", "youth peer support", "youth workforce", "Canadian labor laws". Each term was searched individually first, then in the following combinations (1) peer support and youth peer support and (2) youth workforce and Canadian labour laws. Items were selected by scanning the first 50 results from each search.[52] In keeping with realist methodology[38 41] and the aim to create recommendations for Canadian organisations, the grey literature search had a deliberate focus on publicly available documents from relevant Canadian organisations including Peer Support Canada, OpenCampus BC, Mental Health Commission of Canada (MHCC) and Canada's Drug and Health Technology Agency (CADTH). Documents from the Government of Canada[53 54] outlining considerations for workplace equity were also reviewed, as were provincial documents regarding youth employment laws and standards.[55–57] Grey literature documents were independently reviewed for inclusion by two authors (JH-G and EC) and six research assistants (VS, PL, MF, TS, KB, TA). Documents with recommendations or guidelines for recruitment, career development and other human resource considerations (eg, benefits, reimbursement) specific to the employment of peers were considered for inclusion.

Following the initial search, a second search strategy for primary studies examining the provision of youth peer support for mental health concerns was constructed with a library scientist (DL). CINHAL, MEDLINE, PsycINFO, ERIC, SocINDEX and EmBase databases were searched from 1 January 1979 to 31 July 2025 (online supplemental resource 1); the start date was chosen to reflect when discussions of peer support for mental health concerns first appeared in the literature.[58] Initial inclusion criteria included only studies describing peer support provided by youth to other youth and located in integrated youth services and/or community-based mental health services. Due to limited literature, the inclusion criteria were broadened for the second search to include peer support programmes in community-based mental health services that include youth programming, studies exploring peer support workers' perceptions or experiences of organisational support (including but not limited to hiring, wages, employment status, role definition, best practices) that included peer participants in our identified age range

Table 1 Final inclusion and exclusion criteria

Criteria	Description
Inclusion	English-language, implementation and/or development of youth peer support programmes in integrated youth services and/or community-based mental health services, organisational guidelines/best practices, organisational support (including but not limited to hiring, wages, employment status, role definition) for peer support workers supporting youth with mental health concerns Study design: qualitative, quantitative, mixed-methods.
Exclusion	Unpublished and/or hard to locate full text, peer support for medical conditions (eg, diabetes) or exercise, informal peer support (eg, friendship, family), peer support programmes based in hospital, mental health clinics or physician/therapist offices, peer support delivered to adults (>29 years of age)
Search dates	January 1979 to July 2025

(12–25 years), and studies exploring peers' perceptions or experiences of organisational support that included peer participants working in community-based health supports that include youth programming (table 1). Qualitative, quantitative and mixed-methods studies were included (table 1). Systematic and scoping reviews, literature focused on peer support provided to specific occupations (eg, first responders), included only adult (>25 years old) peer supporters or receivers, informal peer support (eg, friends) or descriptions of peer support training programme content only were not included.

Full search terms are included in online supplemental resource 2. Results were uploaded into Covidence systematic review software (Veritas Health Innovation, Melbourne, Australia. Available at www.covidence.org) and screened independently by reviewers with expertise in youth mental health (JH-G, TH, EC and AB), IYS (TH), programme evaluation (JH-G and TH). Reviewers also included psychology students (MF, TS, KB, TA, VS) and individuals with experience as youth peer support workers (KB). Full texts were reviewed independently by six authors with expertise in youth mental health (JH-G, TH, EC and AB), realist review methodology (TH), programme development and evaluation (JH-G and TH) and qualitative research (TH, EC, BC and JL) for explanations of organisational approaches to creating healthy peer workplaces. In keeping with Pawson's 'fitness to purpose'[38 41] articles that did not clearly fit the inclusion/exclusion criteria (eg, focused on general peer support with limited description of the programme) were evaluated by all four authors for their relevance to the research question and inclusion of information that could contribute to theory development.[38 41] The decision to include these articles was made by consensus; any article with <4/4 agreement between authors was not included. All conflicts were resolved by discussion and consensus.

Data extraction and analysis

An abstraction form with the following deductive categories was developed: candidate theories (composed of common theories associated with peer support), context, mechanism and outcome codes, and organisational information, and study, participant and document characteristics (see online supplemental resource 3). A risk category was added to document contextual factors that impact peers negatively. Context, mechanism and outcome categories were subdivided into peer development, empowerment and equitable employment practices to capture organisational considerations aligned with the theories commonly associated with peer support (Bioecological Model, Self-Determination Theory, Social Cognitive Theory, Social Capital Theory). No formal quality assessment was conducted.[38 39]

Retroductive analysis (both inductive and deductive logic) was used to develop initial CMOCs.[40 59] Deductive coding was guided by the abstraction form. The relationships function in NVivo was used with a subset of articles to identify the interconnections between codes to track and refine programme theories and identify the initial CMOCs. Recognising that the focus of this review was not on programme features as they impact participants, but programme and organisational features as they influence peers, the process for conceptualising programme theories was iterative. In the early stages, traditional CMOCs that describe pathways towards positive outcomes were derived, but as analyses progressed, contextual features that impact peers negatively were also compiled.

The delineation of CMOC codes was based primarily on: (1) relevant organisational or programme attributes (Cs), (2) descriptions of the ways that peers interpret and interact with these organisational/programme features (Ms) and (3) the corresponding dispositional and functional changes that peers experience as a result (Os). Results were discussed and agreed on by four authors (JH-G, TH, EC and AB) and the remaining articles coded to identify support for the initial CMOCs and identify new ones. All initial CMOCs were supported by a breadth of C, M and O codes as well as a minimum of one linking relationship code between them. Initial CMOCs were refined through the examination of the full dataset by (JH-G, TH, EC and AB); all four coders came to consensus on a final list of CMOCs. Three peers from across Canada with previous or current experience working in youth mental health (CE and AD), peer support supervision (AD), programme development (AD and MD), research experience (MD and CE) and familiarity with realist methodologies (MD) reviewed the list of CMOCs and provided recommendations regarding the wording and construction of the CMOCs and risks. The CMOCs and risks that

appear in this manuscript were approved by the authors and the peers. Review procedures occurred between February and August 2024. The updated search (March 2024–July 2025) was conducted in August 2025 and results updated at that time by (JH-G, BC, JL and TH). The updated search did not change the CMOCs or risks.

Patient and public involvement

Peers were involved throughout all phases of the larger research project, including guiding the evolution of research outcomes and areas of focus. Regarding this work, peers were involved in designing the question and confirming results. Peers were presented with the results of the realist review and provided feedback on the CMOCs recommendations and the overall findings. The research team intends to share the results of this work with peers throughout Canada.

RESULTS

Our initial exploratory search identified a total of 30 grey literature documents, including 7 landscape analysis/executive reports, 14 toolkits and 9 organisational statements. Three documents were not specific to peer support, 16 addressed general aspects of peer support (eg, need for lived experience), one discussed a plan to create organisational supports, and 10 focused on general training topics. As a result, all were excluded. A total of 2448 peer-reviewed articles were identified. After removing 547 duplicates, 1901 titles and abstracts were screened and 40 included in the review (figure 1).

Summary of article characteristics

The characteristics of included studies are listed in table 2. Most studies (14; 35%) were conducted in the USA,[18 60–72] followed by Canada (9; 23%)[3 9 11 12 23 73–76] and Australia (7; 18%).[8 16 17 22 77–79] Most studies used either interviews or focus groups to collect data (24; 60%).[3 8 9 11 12 16–18 20 23 60 62 63 65 75–78 80–86] Realist evaluation of a peer support programme was used in five (13%) studies[3 9 12 23 81]; these were the only studies to explicitly identify possible theoretical drivers.

Among the included studies, 21 (53%) focused on non-profit programmes.[3 8 9 12 16 17 20 23 60 68 72 76–79 81 84 85 87–89] Five studies focused on peer-run programmes,[11 60 61 67 89] two of which (40%) were located within traditional mental health settings (including a non-profit programme).[67 89] Most articles focused on peer support programmes for mental health concerns (28; 72%),[3 8 9 11 12 16–18 20 60–67 73 74 77 79–82 84 87–89] while 12 (30%) focused on peer support for substance use.[3 9 11 12 23 60 65–67 75 76 82] Most (25; 63%) studies included peers who were paid employees.[3 8 9 11 12 17 18 20 22 23 60–62 64–67 71–73 75 77 79 80 85]

Qualitative findings

Existing contextual risks associated with youth peer support roles within CYMH

Of the 40 included articles, 27 (68%)[3 9 11 12 16–18 20 22 60–62 65 69 70 76–78 80 82 84–89] described inherent contextual circumstances that are related to peer support programmes and pose a threat to the health and well-being of peers (table 3). According to Tilley,[83] context represents the "conditions [that] are needed for a measure to trigger mechanisms to produce particular outcome patterns" (p. 7). These contextual factors were not intentional components of the organisations; therefore, we did not include them within CMOCs but integrated them into the analyses. Programmes must place them under consideration and prioritise mitigation strategies.

Risk 1: inconsistent or limited employment history creates challenges for entering the job market

Six articles (6; 15%) reported that a challenge for peers entering their roles was being new to the job market, or having inconsistent employment histories.[18 22 61 70 76 88] Both factors impeded their ability to secure employment and created challenges for employers in the hiring process that they endeavoured to overcome.[18 22] Articles expressed the need to ensure that the hiring process reflected the reality that "experiencing mental ill health as a young person (a prerequisite of the role) increases the chances of also experiencing disruption to education and employment, we did not want the application or interview process to act as a further barrier for applicants" (p. 967).[22]

Risk 2: pressure to live up to ideals

Nine articles (23%) highlighted the experiences of peers in trying to manage expectations with respect to their representation of wellness.[3 9 12 17 18 62 78 80 82] Although on a path to recovery, peers experienced fluctuating wellness as they moved forward. Peers in one article reported that this was stressful as "they felt that the program was set up based on the assumption that they were coping well with their mental health. They worried about times when this was not the case" (p. 912).[17]

Risk 3: re-experiencing trauma within the role

Nine articles (23%)[9 16 17 76 77 82 84 86 88] described how peers are exposed to health risks through their work, often through re-experiencing trauma when sharing their previous experiences. This sometimes led to burnout and "challenging situations encountered in the role had the potential to lead to negative outcomes… Risk of burnout or social and emotional harm caused by the peer role is a serious potential consequence both peers and organisations should address" (p. 408).[16]

Risk 4: lack of role clarity

Challenges related to a lack of role clarity were described in 18 (45%) articles.[9 11 16–18 20 22 61 62 65 70 76 78 80 85–88] In part, this issue stemmed from a lack of understanding of the role within other allied professions, and a need for guidelines and training. Researchers identified that part of this issue is related to existing paradigms about professional expertise, the deficit model, therapeutic hierarchies and the notion of maintaining boundaries. It was noted that

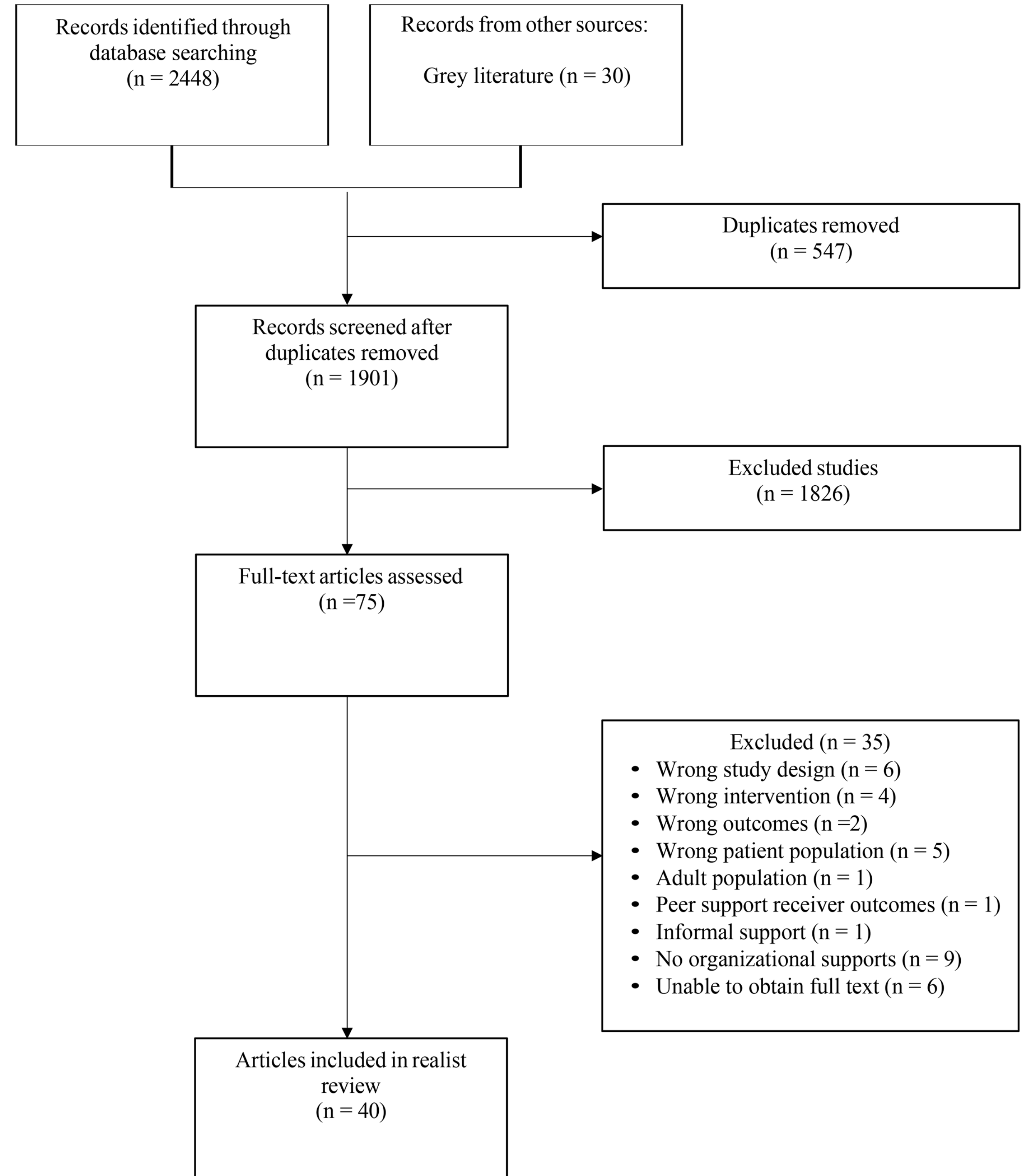

Figure 1 PRISMA diagram. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

"a frequently mentioned barrier by both [peers] in all roles and non-peer colleagues, was the lack of job clarity and existing guidelines for [peers] in practice. Many non-peer colleagues described that for them, it was often not clear how the skills and expertise of [peers] could be applied to practice" (p. 830).[20]

Risk 5: stigma

Stigma remains a significant issue that affects individuals coping with mental health issues; peers described their experience of stigma within their roles in 16 (40%) articles.[3 9 12 17 18 20 22 60–62 69 76 80 86 87 89] Among peers, "a commonly mentioned barrier by some non-peer colleagues and most [peers] in policy, treatment, and research were recurring condescending attitudes and professional stigma towards [peers] s by non-peer colleagues" (p. 828).[20]

CMOCs (middle range/programme theories)

Table 3 lists the specific contexts, mechanisms and outcomes identified through the analysis. Of the six CMOCs developed, two addressed creating equitable

Table 2 Study characteristics of included studies

Study characteristic	No. of studies	References
Geographic Location		
USA	14 (35%)	[18 60–72]
Canada	9 (23%)	[3 9 11 12 23 73–76]
Australia	7 (18%)	[8 16 17 22 77–79]
UK	5 (13%)	[77 81 85 88 89]
Other	4 (10%)	[20 80 82 84]
Study Design*		
Individual semistructured interviews	18 (45%)	[3 8 9 12 16 18 20 23 62 65 75–77 80–82 84]
Focus groups	16 (40%)	[3 8 9 12 16 18 20 23 62 65 75–77 80–82 84]
Survey study	12 (30%)	[11 61 65–68 71 74 81 84 87 88]
Hybrid participatory-realist evaluation	5 (13%)	[3 9 12 23 81]
Observational study	4 (10%)	[64 66 67 79]
Case study	5 (13%)	[60 68 69 72 89]
Other	4 (10%)	[22 70 73 86]
Paid or volunteer work*		
Paid	25 (63%)	[3 8 9 11 12 17 18 20 22 23 60–62 64–67 71–73 75 77 79 80 85]
Volunteer	4 (10%)	[68 74 82 84]
Both	7 (18%)	[11 63 69 71 87–89]
NR	4 (10%)	[73 76 81 86]
Organisation type*		
Charity/non-profit	21 (53%)	[3 8 9 12 16 17 20 23 60 68 72 76–79 81 84 85 87–89]
Healthcare system	12 (30%)	[11 17 20 22 60 61 79 81 82 87 89]
Education system	6 (15%)	[64 68 74 81 87]
Peer-run	5 (13%)	[11 60 61 67]
Criminal/juvenile justice system	4 (10%)	60,69,76,85[60 69 87 88]
Other	4 (10%)	[60 69 79 81]
NR	11 (28%)	[18 62 63 65–67 70 71 73 75 86]
Practice setting*		
Traditional mental health settings (n=15)*		
Hospital inpatient units	5 (33%)	[60 61 76 80 81 89]
Outpatient clinics	8 (53%)	[60 61 63 65–67 81 82]
Unspecified	5 (33%)	[20 62 70 87 88]
Community-based mental health settings	27 (68%)	[3 8 9 11 12 16–18 20 22 23 60 61 65 66 72 75–77 79 81 82 84 85 87–89]
Schools	9 (23%)	[64 65 68 74 75 79 81 87 88]
Police Services/correctional facilities	3 (8%)	[60 87 88]
Other	5 (13%)	[69 71 73 78 86]
Youth consumer mental health characteristics*		
Mental health concerns/disorders	28 (72%)	[3 8 9 11 12 16–18 20 60–67 73 74 77 79–82 84 87–89]
Substance use concerns/disorders	12 (30%)	[3 8 9 11 12 23 60 65–67 75 76 82]
Exposure to traumatic events	2 (5%)	[68 89]
NR	10 (25%)	[60 70 71 76 78 85–88]

*Adds to >40 (100%) as some studies were included in >1 category.
No., number; NR, not reported.

Table 3 Context, mechanism and outcome findings

	Citation
Context	
Clear role description	9 11 16 18 22 61 62 74–76 78 85–87 89
Effective supervision	3 8 11 12 16–18 20 61 62 64 69 82 84–86 89
Organisations create defined peer supporter competencies, training and/or certification plan and employment pathway	3 8 11 12 17 60 62 64 66 67 69 70 75–78 86 87 89
Strengthened insight from hardship	8 11 61 65 82 86 87 89
Peer support values supporting others	3 11 62 63 66 81 85 88 89
Organisation is adaptable to peer voice	3 8 12 16 17 61 64 70 71 76 79 82 87
Mechanism	
Development of staff understanding of and buy-in for peers	3 9 11 17 18 20 22 61 62 70 75 76 89
Peers develop self-care and sustainable work strategies and peers recognise and implement appropriate boundaries	3 8 11 12 18 62 64 74 75 78–80 82 85–87 89
Opportunities for peers to practise professional skills	3 8 12 69 70 76 81 85–88
Peers use lived experience to help others and peers recognise the value of their lived experience	3 9 11 23 62 63 65 66 73 75 79 82 85 87 89
Peers recognise their value and experience increased peer sense of purpose	3 8 16 62 80 82 87
Opportunities for peers to contribute to organisational development and peers perceive their voice as relevant and valuable	3 8 12 62 70 71 76 77 79 85 87
Outcome	
Reduction in professional stigma	3 20 70 78 86 88 89
Stronger self-care and enhanced resilience	3 8 12 72 83 84 89
Employability and career advancement	3 8 12 16 17 60 64 70 76 83–85 87
Peers progress in recovery-resilience and overcome stigma	3 16 18 23 60 72 84 87
Increased peer confidence, self-esteem, self-worth, well-being	3 11 16–18 71 78 81 82 85 88
Peer supporters continue to develop self-efficacy and self-determination	3 11 12 17 71 78 82 88
Risks	
Inconsistent or limited employment history creates challenges for entering the job market	18 22 61 70 76 88
Pressure to live up to ideals	3 9 12 17 18 62 78 80 82
Re-experiencing trauma within the role	9 16 17 76 77 82 84 86 88
Lack of role clarity	9 11 16–18 20 22 61 62 65 70 76 78 80 85–88
Stigma	3 9 12 17 18 20 22 60–62 69 76 80 86 87 89

employment, three addressed promotion of peer development and one addressed peer empowerment (figure 2).

Creating equitable employment

1. Clear role description+Ddevelopment of staff understanding of and buy-in for peers → Reduction in professional stigma.

   To mitigate issues related to a lack of role clarity, the creation of a clear role description was recommended by a broad range of experts.[9 11 16 18 22 61 62 70 73 75 77 78 85–87 89]

   Defining the role and its' functions enhanced understanding of the peer support role's contribution. This can lead to greater support for peers and a reduction in stigma.[3 20 70 78 86 88 89] Furthermore, there is a need for increased staff awareness of the peer role within each agency setting. This process includes defining the essential job functions of a peer in accordance with the peer role ethical code and individual agency context, as well as ensuring that administration and peer colleagues understand this role.[18] As noted by Simmons *et al*[17], stigma towards peers may be diminished through a greater recognition of the value of lived experience.
2. Effective supervision+Peers develop self-care and sustainable work strategies and peers recognise and implement appropriate boundaries → Stronger self-care and enhanced resilience.

Existing risks associated with youth peer support roles within CYMH

- Inconsistent or limited employment history creates challenges for entering the job market
- Pressure to live up to ideals
- Re-experiencing trauma within the role
- Lack of role clarity
- Stigma

CMOCs relevant to creating equitable employment

Clear role description + Development of staff understanding of and buy-in for peers ➔ Reduction in professional stigma

Effective supervision + Peers develop self-care and sustainable work strategies & peers recognize and implement appropriate boundaries ➔ Stronger self-care and enhanced resilience

CMOCs relevant to the promotion of peer development

General youth development - CMOCs

Organization creates defined peer supporter competencies, training/certification plan and employment pathway + Peer engagement and familiarization with professional skills ➔ Employability career advancement

Strengthened insight from hardship + Peers use lived experience to help others & peers recognize the value of their lived experience ➔ Peers progress in recovery-resilience and overcome stigma

Peer support practice values supporting others + Peers recognize their value and experience increased sense of purpose ➔ Increased peer confidence, self-esteem, self-worth, wellbeing

Empowerment - CMOCs

Organization is adaptable to peer voice + Peers meaningfully contribute to organizational development & peers perceive their voice as relevant and valuable ➔ Peer supporters develop increased self-efficacy and self-determination

Related Recommendations:

Create an accessible employment process
Maintain a responsive organizational environment

Develop employment supports and benefits for peers
Develop effective training, supervision and mentorship structures

Figure 2 Risks and programme theories. CMOCs, Context-Mechanism-Outcome Configurations; CYMH, child and youth mental health.

The functional importance of supervision was emphasised in most articles.[3 8 11 12 16–18 20 61 62 64 69 75 76 78 85 86 89] Pathways of influence were often reflected in peers' self-care practices, resilience within their work and the importance of supervision in recognising the uniqueness of peer support work. Peers noted that "it is hard to keep my balance. For that, I have to keep a certain level of distance, but, at the same time, I have to stay in this close contact with the patient … where my experience allows me to connect with them, to better understand them. When I shut down this part of me, my experience, then I am also losing this special bond. The big challenge is to protect myself so I don't get triggered or too involved" (p. 265).[80] "Through supervision, peers were able to work through some of their challenges and achieve further personal development. Part of this was recognizing that peers might need more care as they transition out of formal services" (p. 6).[3]

Promotion of peer development

1. Organisation creates defined peer supporter competencies, training/certification plan and employment pathway+Peer engagement and familiarisation with professional skills → Employability and career advancement.
2. Strengthened insight from hardship+Peers use lived experience to help others & Peers recognise the value of their lived experience → Peers progress in recovery-resilience and overcome stigma.
3. There was support for a CMOC that describes a reciprocal influence on peers that is derived from leveraging their lived experience to help others achieve wellness.[3 9 11 16 18 23 62 63 65 67 75 79 82 85–87 89] One peer noted that "it's like learning to value yourself for more than what you were valued as originally… unfortunately within the real world we don't really tend to value ourselves that much-so, to be put in a place where you can be in the real world and valued, it's a big eye opener" (p. 144).[85] Importantly, "peers using their lived experiences in peer practice helps them to recognize the value of that experience and subsequently supports them in overcoming related stigma" (p. 7).[3]

There was strong support for a mechanism of influence that is created by organisational supports that facilitate skill development and career advancement for peers.[3 8 11 12 16–18 60 62 64 66 67 70 72 73 75–78 85–89] This is a clear benefit as it can establish these young people in upward employment that ultimately contributes to their independence and well-being. As noted in Simmons *et al*,[17] "these developments didn't just allow the [peer] to do their job but also instilled hope in their educational and vocational prospects" (p. 909). Furthermore, "The [peer] role provides young adults, particularly those with limited post-secondary education and/or job experiences, an opportunity to obtain a professional job, learn transferable skills, build resumes and network towards a career path (p. 812).[18]

1. Strengthened insight from hardship+Peers use lived experience to help others and Peers recognise the value of their lived experience → Peers progress in recovery-resilience and overcome stigma.

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wellness.[3 9 11 16 18 23 62 63 65 67 76 78 82 84 87–89] One peer noted that "it's like learning to value yourself for more than what you were valued as originally… unfortunately within the real world we don't really tend to value ourselves that much-so, to be put in a place where you can be in the real world and valued, it's a big eye opener" (p. 144).[88] Importantly, "peers using their lived experiences in peer practice helps them to recognize the value of that experience and subsequently supports them in overcoming related stigma" (p. 7).[3]

2. Peer support practice values supporting others+Peers recognise their value and experience increased sense of purpose → Increased peer confidence, self-esteem, self-worth, well-being.

A number of studies described a process whereby organisations conveyed that peers were valuable and held in high esteem.[3 8 11 16–18 61–63 70–74 81 82 85–87 89] This enhanced peer's sense of purpose, confidence and well-being as noted in Tisdale *et al*[16]: "all [peers] discussed the rewarding nature of the role and its contribution to a feeling of purpose, with some peers believing this had positive implications for their sense of value and mental health… Peers felt this positioned them uniquely within the organisation, contributing to their feelings of legitimacy and value" (p. 404).

Peer empowerment

1. Organisation is adaptable to peer voice+Peers meaningfully contribute to organisational development & peers perceive their voice as relevant and valuable → Peer supporters develop increased self-efficacy and self-determination.
2. The literature clearly described how incorporating peer voices in organisational decision-making enhanced their personal value among peers and supported growth and development.[3 8 11 12 16 17 62 64 70 71 76–79 85 87 88] Peers used growth in their personal skills and in the overall programme to move beyond the initial "gaps that they filled (T2) towards imagining a vision for greater expansion of the program" (p. 910).[17] Peers reported feeling like they "have a purpose in this role… It's helped my confidence a lot to just think that I have ideas that are worth sharing to other people" (p. 4).[3]

DISCUSSION

This review contributes to the field of knowledge on peer support through the synthesis of findings that describe the contexts and mechanisms that operate within workplace settings that impact peers. Programme theories (CMOCs) developed in this review align with practices that mitigate inherent risk factors within peer support environments and describe organisational attributes that foster peer development through their employment experiences. Realist methods have been applied to examine underlying theory within peer support programming[12 23 80] and to examine how organisational contexts might influence peer outcomes.[3] This synthesis builds on this prior work by consolidating relevant programme theories across studies to identify common mechanisms of influence as well as common risk factors. The programme theories derived from the analysis relate to: (1) increased role clarity, (2) effective supervision, (3) creation of career pathways, (4) developing purpose through helping, (5) decreased stigma through valuing lived experience and (6) increasing self-determination through contribution (figure 2). Common risks affecting peers within their roles include challenges related to job entry, pressure to live up to ideals of health, exposure to trauma and stresses related to a lack of role clarity. These results serve as a foundation for the development of guidelines that can be used by organisations looking to implement and sustain a healthy and sustainable youth peer support workforce.

This work emphasises the need to address the imbalances within organisations employing youth peers, while highlighting the demands, expectations and rewards (including salary, value and respect) of the peer support role. Indeed, a common underlying theme across the identified risks and CMOCs was the impact of workplace conditions on peer health and well-being. This is not unique to the peer role. Working conditions have long been considered a social determinant of health;[44 90] however, the considerations have only recently widened beyond occupational safety and physical hazards to include the psychological risks (eg, distress, burnout).[44 91] Job insecurity is common among peers[89 92] and has been associated with poor self-rated health and the onset or worsening of existing depression, anxiety and distress in the general workforce.[93–95] Beyond job security, roles with low pay or limited hours contribute to poor health by reducing social power and access to healthcare and retirement plans.[91 96] Our findings highlight the need for organisations to address insecurity, particularly low wages and contract work, in their peer workforce to improve health and wellness outcomes. Precarity for peers can be seen in the uncertainties surrounding where they fit in the structure of an organisation, their risk of being retraumatised through their work, experience of professional stigma and limited ability and/or power to advocate for change in their role, pay or development compared with non-peer staff.[8 16 20 22] The CMOCs identified in this review describe processes that can mitigate and eliminate these existing challenges.

As discussed earlier, there has been less consideration of theory with respect to individual peer development as opposed to client development within peer support. CMOCs identified within our analysis align with previous work examining processes of development that influence peer development as it relates to: (1) the importance of supervision and the enhancement of peer capacity and resilience, (2) skill development and sustainable employment, (3) meaningful contribution to programme development and self-efficacy/self-determination and (4) valuing of lived experience and enhanced self-worth/esteem.[3] Our findings also align with recovery processes described in the CHIME framework, in particular identity (CMOCs 4 and 5) as well as empowerment (CMOC 6).[33]

Recommendations and next steps

Through our review, we compiled recommendations that align with the CMOCs and can serve to create healthy contexts for peers (figure 2). These include: (1) making employment processes (including hiring and training practices) more accessible to peers by creating meaningful roles and providing support and benefits that reflect peer support values, including mental health support and paid leave for ongoing recovery,[9 16 18] (2) providing supportive supervision for peers, particularly through promotion of individuals with experience as a peer support worker and training for non-peer employees regarding what peer support is and, importantly, what it is not,[12 18 20 22] (3) creating an organisational environment that is responsive to the peer voice and expertise[17 18] and (4) ensuring that employment supports and benefits are provided to peer support staff.[16 18 22]

Like Saad *et al*,[8] a key theme underpinning our findings was the need for organisations to formally recognise peers and prioritise peer support values to support peer progress in recovery-resilience and stigma reduction. Development and implementation of policies that prevent organisations from devaluing and deskilling workers would contribute to the development of decent work for peers. Beyond mental health organisational contexts, there is a need to continue to address inequities perpetuated through social and structural stigma. As mental health issues can have negative impacts on financial independence,[14] supporting greater income distribution such as through progressive taxation, increasing social assistance and the minimum wage, investing in disability supports and expanding the social safety net[97] would advance health equity for, and likely decrease stigmatising attitudes towards, individuals impacted by mental health issues. It should be recognised that, as with other systemic issues, stigma cannot be addressed through educational campaigns alone[98 99] but through broader policy focused on the redistribution of wealth and power.[99]

Our recommendations, along with considerations related to the CMOCs, can inform the development of guidelines to enhance workplace environments for peers. Kastner *et al*[100] identified six key components of guideline development, including stakeholder involvement, evidence synthesis, considered judgement, implementation feasibility, message and format. Realist reviews, including the present study, support the development of flexible, practical guidelines through the involvement of stakeholders in the design (eg, involvement of peers and peer support experts in CMOC development), synthesis of a variety of evidence (eg, inclusion of peer-reviewed and grey literature), and considered judgement (eg, consideration of practice in different contexts). As a next step, guideline development tools, such as the redesigned Appraisal of Guidelines, Research and Evaluation[101] can be applied to translate these findings into functional practice standards.

Peer workplace environments do not exist in isolation and are influenced by broader policy focused on healthy work environments. In Canada, and globally, inequities have been increasing.[97 102] Within Canada, income inequality has increased to its highest level since the late 1990s with the gap between the disposable income of the top two and the bottom two fifths of the population reaching 47%.[103] Many individuals who are coping with mental health issues (and peers working in mental health services) are more likely to be experiencing socioeconomic difficulties.[104 105] Our recommendations to reduce workplace precarity for peers are not dissimilar from the basic requirements that should be applied to all workplaces. As such, our recommendations support better job security and healthier working conditions. Raphael *et al*[97] offer policy recommendations that can help to better working conditions including: (1) mandates for institutions to provide basic standards of employment, (2) creation of legislation targeting inequalities through equal opportunity in hiring, compensation and training, (3) increased government support to improve access to income, training and work opportunities for the unemployed, (4) inclusion of representatives from policy, employer and employee stakeholder groups in codesigning a new conceptualisation of healthy, productive workplaces, (5) development of policies that balance demands and rewards for employees, (6) place special attention on high stress roles (such as peer roles) to increase employee control and moderate demands, (7) increase unionisation and (8) invest in more research focused on work-related policy. Without recognition of, and focus on, supporting greater health equity in Canada, peers will continue to suffer, along with other low-income Canadians within precarious work environments.

Limitations and strengths

This review has several limitations. Relevant studies may have been missed due to the English-language restriction. Few studies examined organisational contexts/guidelines/policy informing the delivery of peer support to youth, and none focused exclusively on peer support provided by youth peers. The lack of peer-run organisations identified in empirical research and publicly accessible grey literature limited our ability to thoroughly examine how these settings impact peer employment experiences. The grey literature focused almost exclusively on the content of training programmes, resulting in limited evidence regarding implementation and impact. There may be some incoherence in the findings as a result of the wide range of existing peer support roles. It may be beneficial for future research to examine more specific job functions and roles to identify more delineated pathways of influence. Finally, the grey literature was limited to available Canadian open-access texts and regulations, which may limit generalisability. In terms of strengths, the involvement of peers and a peer support supervisor throughout this work ensured that our findings were grounded in lived experience. This work represents a novel application of the rapid realist review and is, to our knowledge, the first to use realist

methods to examine the organisational contexts and the mechanisms underlying provision of equitable employment and supporting peer development within CYMH. Rather than applying the method to examine influences on programme beneficiaries at a programme level, we used it to examine organisational influences on a specific role, thereby identifying ways to create healthier employment contexts. Finally, this work offers a systematic examination of potential future directions that serve to: (1) offer guidance to improve employment practice within the mental health system, (2) reinforce services through greater workforce development and (3) advance health equity through the expansion of healthy organisational contexts.

CONCLUSIONS

This review identified that equitable peer employment is most likely to be created through mechanisms that reduce professional stigma and enhance peer resilience. Mechanisms that support general development empower peers, contributing to career and personal development. Organisations that implement accessible employment processes, supports and benefits for peers within a responsive environment are most likely to build and sustain a healthy youth peer support workforce. Peer work environments are also the result of broader policy on workplace conditions. Advancements must be made that support policy designed to create equity in the workplace; otherwise, precarious work conditions will persist. This review provides insight into the complexity underlying the implementation of youth peer support programmes in a variety of youth-serving contexts and will inform the development of organisational guidelines that mitigate potential risks while supporting the development of healthier organisational contexts.

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REFERENCES

1 Mental Health Commission of Canada. Peer support. 2021. Available: https://mentalhealthcommission.ca/what-we-do/access/peer-support/ [Accessed 4 Oct 2024].
2 Canada's Drug and Health Technology Agency. Peer support programs for youth mental health: project protocol. 2022. Available: https://www.cadth.ca/sites/default/files/hta-he/HT0036%20Peer%20Support%20Youth%20 Protocol.pdf [Accessed 23 Feb 2024].
3 Halsall T, Daley M, Hawke LD, *et al*. "You can create a little bit more closure in your own story when someone really connects with it": exploring how involvement in youth peer support work can promote peer development. *Int J Ment Health Syst* 2023;17:34.
4 Simmons MB, Cartner S, MacDonald R, *et al*. The effectiveness of peer support from a person with lived experience of mental health challenges for young people with anxiety and depression: a systematic review. *BMC Psychiatry* 2023;23:194.

5 Walker JS, Baird C, Welch MB. *Peer support for youth and young adults who experience serious mental health conditions: state of the science*. Research and Training Center for Pathways to Positive Futures, 2018. Available: https://www.pathwaysrtc.pdx.edu/pdf/state-of-the-science-articles-2018-amp-plus.pdf
6 Fortuna KL, Solomon P, Rivera J. An Update of Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. *Psychiatr Q* 2022;93:571–86.
7 LaMarre A, Wozney L, Obeid N, *et al*. Peer mentors' experiences of delivering peer support for individuals with eating disorders: giving back and supporting processes of change. *Eat Disord* 2025;33:750–64.
8 Saad G, Honey A, Schaecken P, *et al*. Strategies and supports used by mental health peer workers to facilitate role performance and satisfaction. *Advances in Mental Health* 2024;22:179–95.
9 Halsall T, Daley M, Hawke LD, *et al*. "I Think Peer Support Helps to Demystify People Who Have Mental Health Issues and Helps to Remove That Stigma": Exploring the Defining Characteristics and Related Challenges of Youth Peer Support Through Participatory Research. *Community Ment Health J* 2024;60:784–95.
10 Dimitropoulos G, Cullen E, Hews-Girard JC, *et al*. Examining the experiences of student peer support workers delivering care within post-secondary institutions. *J Am Coll Health* 2025;73:3164–73.
11 Hews-Girard JC, Cullen E, Sauerwein J, *et al*. Key Considerations in Integrating a Peer Support Model Within Psychiatric Emergency Services at a Canadian Pediatric Emergency Department: A Qualitative Study. *Community Ment Health J* 2025;61:576–86.
12 Halsall T, Daley M, Hawke L, *et al*. Exploring Peer Support Services for Youth Experiencing Multiple Health and Social Challenges in Canada: A Hybrid Realist-Participatory Evaluation Model. *Int J Qual Methods* 2021;20:1–13.
13 Hews-Girard JC, Cullen E, Singh M, *et al*. Identifying 'Where' and 'How' Peer Support for Youth is Integrated into Community-Based Mental Health Services: A Survey Study. *Community Ment Health J* 2025;61:994–1004.
14 Corrigan PW, Kerr A, Knudsen L. The stigma of mental illness: Explanatory models and methods for change. *Applied and Preventive Psychology* 2005;11:179–90.
15 Kidd SA, Vitopoulos N, Frederick T, *et al*. Peer Support in the Homeless Youth Context: Requirements, Design, and Outcomes. *Child Adolesc Soc Work J* 2019;36:641–54.
16 Tisdale C, Snowdon N, Allan J, *et al*. Youth Mental Health Peer Support Work: A Qualitative Study Exploring the Impacts and Challenges of Operating in a Peer Support Role. *Adolescents* 2021;1:400–11.
17 Simmons MB, Grace D, Fava NJ, *et al*. The Experiences of Youth Mental Health Peer Workers over Time: A Qualitative Study with Longitudinal Analysis. *Community Ment Health J* 2020;56:906–14.
18 Delman J, Klodnick VV. Factors Supporting the Employment of Young Adult Peer Providers: Perspectives of Peers and Supervisors. *Community Ment Health J* 2017;53:811–22.
19 de Beer CRM, Nooteboom LA, van Domburgh L, *et al*. A systematic review exploring youth peer support for young people with mental health problems. *Eur Child Adolesc Psychiatry* 2024;33:2471–84.
20 de Beer CRM, Nooteboom LA, van Domburgh L, *et al*. Correction to: A systematic review exploring youth peer support for young people with mental health problems. *Eur Child Adolesc Psychiatry* 2024;33:1233.
21 Hopkins L, Pedwell G, Wilson K, *et al*. Implementing youth peer support in an early psychosis program. *JMHTEP* 2021;16:85–98.
22 Simmons MB, Coates D, Batchelor S, *et al*. The CHOICE pilot project: Challenges of implementing a combined peer work and shared decision-making programme in an early intervention service. *Early Intervention Psych* 2018;12:964–71.
23 Halsall T, Daley M, Hawke L, *et al*. "You can kind of just feel the power behind what someone's saying": a participatory-realist evaluation of peer support for young people coping with complex mental health and substance use challenges. *BMC Health Serv Res* 2022;22:1358.
24 DeLuca JS. Conceptualizing Adolescent Mental Illness Stigma: Youth Stigma Development and Stigma Reduction Programs. *Adolescent Res Rev* 2020;5:153–71.
25 Tam T. *Addressing stigma: towards a more inclusive health system [online]*. Public Health Agency of Canada, 2019. Available: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf
26 Bandura A. Social Cognitive Theory: An Agentic Perspective. *Psychology (Irvine)* 2005;12:313.
27 Bandura A. A Social Cognitive perspective on Positive Psychology. *International Journal of Social Psychology: Revista de Psicología Social* 2011;26:7–20.
28 Barton J, Henderson J. Peer Support and Youth Recovery: A Brief Review of the Theoretical Underpinnings and Evidence. *CJFY* 2016;8:1–17.
29 Alvarez-Jimenez M, Gleeson JF, Rice S, *et al*. Online peer-to-peer support in youth mental health: seizing the opportunity. *Epidemiol Psychiatr Sci* 2016;25:123–6.
30 Hosek SG, Lemos D, Harper GW, *et al*. Evaluating the acceptability and feasibility of Project ACCEPT: an intervention for youth newly diagnosed with HIV. *AIDS Educ Prev* 2011;23:128–44.
31 Stewart M, Reutter L, Letourneau N, *et al*. A support intervention to promote health and coping among homeless youths. *Can J Nurs Res* 2009;41:55–77.
32 Bronfenbrenner U, Morris PA. *The bioecological model of human development*. New York: John Wiley & Sons Inc 2006:793–828, 2006:793–828.
33 Leamy M, Bird V, Le Boutillier C, *et al*. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br J Psychiatry* 2011;199:445–52.
34 Dallinger VC, Krishnamoorthy G, du Plessis C, *et al*. Conceptualisation of Personal Recovery and Recovery-Oriented Care for Youth: Multisystemic Perspectives. *Int J Ment Health Addiction* 2025;23:1308–32.
35 Bliss C. Introduction on the theory of capital: a personal overview. In: Bliss C, Cohen AJ, Harcourt GC, eds. *Capital theory*. Cheltenham, UK: Edward Eldgar Publishing, 2005: 11–25.
36 Bourdieu P. *The forms of capital*. 1986. . New York: Greenwood, n.d.:241–58.
37 Kastner M, Tricco AC, Soobiah C, *et al*. What is the most appropriate knowledge synthesis method to conduct a review? Protocol for a scoping review. *BMC Med Res Methodol* 2012;12:1–10.
38 Pawson R, Greenhalgh T, Harvey G, *et al*. Realist review - a new method of systematic review designed for complex policy interventions. *J Health Serv Res Policy* 2005;10:21–34.
39 Saul JE, Willis CD, Bitz J, *et al*. A time-responsive tool for informing policy making: rapid realist review. *Implement Sci* 2013;8:103.
40 Greenhalgh T, Wong G, Westhorp G, *et al*. Protocol--realist and meta-narrative evidence synthesis: evolving standards (RAMESES). *BMC Med Res Methodol* 2011;11:115:1–10:.
41 Pawson R. *Evidence-based policy: a realist perspective*. London: Sage Publications, 2006:1–208.
42 Westhorp G. *Understanding mechanisms in realist evaluation and research*. London: SAGE Publications Ltd, 2018:41–58.
43 Berg RC, Nanavati J. Realist review: current practice and future prospects. *J Res Pract* 2016;12:1–28. Available: https://jrp.icaap.org/index.php/jrp/article/view/538.html
44 National Collaborating Centre for Determinants of Health. Determining health: decent work issue brief [online], 2022. Available: https://nccdh.ca/resources/entry/determining-health-decent-work-issue-brief [Accessed 4 Oct 2024].
45 International Labour Organization. Decent work [online]. 2023. Available: https://www.ilo.org/topics/decent-work [Accessed 4 Oct 2024].
46 Cohen KA, Stiles-Shields C, Winquist N, *et al*. Traditional and Nontraditional Mental Healthcare Services: Usage and Preferences Among Adolescents and Younger Adults. *J Behav Health Serv Res* 2021;48:537–53.
47 Moghimi E, Stephenson C, Gutierrez G, *et al*. Mental health challenges, treatment experiences, and care needs of post-secondary students: a cross-sectional mixed-methods study. *BMC Public Health* 2023;23:655.
48 Ng P, Padjen M. An Overview of Post-Secondary Mental Health on Campuses in Ontario: Challenges and Successes. *Int J Ment Health Addiction* 2019;17:531–41.
49 Hawke LD, Mehra K, Settipani C, *et al*. What makes mental health and substance use services youth friendly? A scoping review of literature. *BMC Health Serv Res* 2019;19:257:257:.
50 World Economic Forum. A global framework for youth mental health [online]. 2020. Available: https://www3.weforum.org/docs/WEF_Youth_Mental_Health_2020.pdf [Accessed 4 Oct 2024].
51 Wong G, Greenhalgh T, Westhorp G, *et al*. Development of methodological guidance, publication standards and training materials for realist and meta-narrative reviews: the RAMESES (Realist And Meta-narrative Evidence Syntheses – Evolving Standards) project. *Health Services and Delivery Research* 2014;2:1–252.
52 University of British Columbia. Grey literature [online]. 2025. Available: https://guides.library.ubc.ca/greylitforhealth/document

53 Government of Canada. How to improve workplace equity: evidence-based actions for employers [online]. 2022. Available: https://www.canada.ca/en/employment-social-development/corporate/portfolio/labour/programs/employment-equity/reports/employers-improve-workplace.html [Accessed 23 Feb 2024].
54 Government of Canada. About the workplace equity program [online]. 2023. Available: https://www.canada.ca/en/employment-socialdevelopment/corporate/portfolio/labour/programs/employment-equity.html
55 British Columbia Ministry of Health Services. Peer support: resource manual. 2021. Available: https://www.health.gov.bc.ca/library/publications/year/2001/MHA_Peer_Support_Manual.pdf
56 British Columbia's Office of the Human Rights Commissioner. An introduction to employment equity [online]. 2022. Available: https://bchumanrights.ca/wp-content/uploads/2024/05/Infosheet_Introduction-employment-equity.pdf
57 British Columbia's Office of the Human Rights Commissioner. Equitable compensation in the workplace [online]. 2022. Available: https://bchumanrights.ca/wp-content/uploads/2024/05/Infosheet_equitable-compensation.pdf [Accessed 23 Feb 2024].
58 Devoe D, Jomha A, Campbell C, *et al*. Peer support for youth with mental health concerns: a scoping review. [Preprint] 2024.
59 Dalkin S, Forster N, Hodgson P, *et al*. Using computer assisted qualitative data analysis software (CAQDAS; NVivo) to assist in the complex process of realist theory generation, refinement and testing. *Int J Soc Res Methodol* 2021;24:123–34.
60 Chapman SA, Blash LK, Mayer K, *et al*. Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders. *Am J Prev Med* 2018;54:S267–74.
61 Clossey L PhD, LCSW, Solomon P PhD, Hu C PhD, *et al*. Predicting job satisfaction of mental health peer support workers (PSWs). *Soc Work Ment Health* 2018;16:682–95.
62 Gates LB, Akabas SH. Developing strategies to integrate peer providers into the staff of mental health agencies. *Adm Policy Ment Health* 2007;34:293–306.
63 Hiller-Venegas S, Gilmer TP, Jones N, *et al*. Clients' Perspectives Regarding Peer Support Providers' Roles and Support for Client Access to and Use of Publicly Funded Mental Health Programs Serving Transition-Age Youth in Two Southern California Counties. *J Behav Health Serv Res* 2022;49:364–84.
64 Horton L, Conrad A, Smith PJ. Promoting holistic wellness in honors students through peer coaching. *Honors in Practice* 2023;19:17–27. Available: https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1389&context=nchchip
65 Magana C, Gilmer TP, Munson MR, *et al*. Programmatic Support for Peer Specialists that Serve Transition Age Youth Living with Serious Mental Illness: Perspectives of Program Managers from Two Southern California Counties. *Community Ment Health J* 2023;59:1498–507.
66 Ojeda VD, Jones N, Munson MR, *et al*. Roles of peer specialists and use of mental health services among youth with serious mental illness. *Early Intervention Psych* 2021;15:914–21.
67 Ojeda VD, Munson MR, Jones N, *et al*. The availability of peer support and disparities in outpatient mental health service use among minority youth with serious mental illness. *Adm Policy Ment Health* 2021;48:290–8.
68 Richards M, Dusing CR, Miller KM, *et al*. Stress, resilience, and empowerment: a trauma-informed peer mentoring model for youth of color. In: Garo LA, Butler BR, Lewis CW, eds. *Un-silencing youth trauma: Transformative school-based strategies for students exposed to violence & adversity*. Chicago: Information Age Publishing, Inc, 2022: 39–58.
69 Research and Training Center for Pathways to Positive Futures and Youth and Family Training Institute. Implementing the peer support specialist role: providing direct, individualized support in a local program [online], 2013. Available: https://pdxscholar.library.pdx.edu/cgi/viewcontent.cgi?article=1444&context=socwork_fac [Accessed 24 Feb 2024].
70 Wolf J, Lawrence LH, Ryan PM, *et al*. Emerging Practices in Employment of Persons in Recovery in the Mental Health Workforce. *Am J Psychiatr Rehabil* 2010;13:189–207.
71 Wu JR, Iwanaga K, Chan F, *et al*. Positive Organizational Psychology Factors as Serial Multiple Mediators of the Relationship between Organization Support and Job Satisfaction Among Peer Support Specialists. *J Occup Rehabil* 2023;33:121–33.
72 Youth Move Oregon. Implementing the peer support specialist role: peer support in a youth-led drop-in center [online]. 2014. Available: https://www.pathwaysrtc.pdx.edu/pdf/proj4-YMO-peer-support-case-study.pdf
73 Libon J, Alganion J, Hilario C. Youth Perspectives on Barriers and Opportunities for the Development of a Peer Support Model to Promote Mental Health and Prevent Suicide. *West J Nurs Res* 2023;45:208–14.
74 Suresh R, Karkossa Z, Richard J, *et al*. Program evaluation of a student-led peer support service at a Canadian university. *Int J Ment Health Syst* 2021;15:54.
75 Turuba R, Toddington C, Tymoschuk M, *et al*. "A peer support worker can really be there supporting the youth throughout the whole process": a qualitative study exploring the role of peer support in providing substance use services to youth. *Harm Reduct J* 2023;20:118.
76 Devane C, Jenkins E, McAuliffe C, *et al*. Service providers' perspectives on youth peer support: the importance of integration and oversight - an interpretive description study in British Columbia, Canada. *BMJ Open* 2025;15:e094356.
77 Walsh PE, McMillan SS, Stewart V, *et al*. Understanding paid peer support in mental health. *Disability & Society* 2018;33:579–97.
78 Kemp V, Henderson AR. Challenges faced by mental health peer support workers: peer support from the peer supporter's point of view. *Psychiatr Rehabil J* 2012;35:337–40.
79 Siantz E, Center K, Lansing AE, *et al*. 'We're not a separate entity, we're staff now' The involvement of transition age youth peer supporters in trauma-informed community partnerships. *Child Youth Serv Rev* 2023;144:106701.
80 Otte I, Werning A, Nossek A, *et al*. Challenges faced by peer support workers during the integration into hospital-based mental health-care teams: Results from a qualitative interview study. *Int J Soc Psychiatry* 2020;66:263–9.
81 Thompson DM, Bernard M, Maxfield B, *et al*. Focusing a realist evaluation of peer support for paediatric mental health. *Discov Ment Health* 2023;3:18.
82 de Beer CRM, Vermeiren RRJM, Nooteboom LA, *et al*. A balancing act: integrating the expertise of youth peer workers in child and adolescent mental health services. *Eur Child Adolesc Psychiatry* 2025;34:327–39.
83 Tilley N, Pawson R. Realist evaluation: an overview. Founding Conference of the Danish Evaluation Society; 2000
84 Lauridsen S, Nielsen MBD, Kusier AO, *et al*. Implementing a peer-to-peer, self-management intervention for young people with depression and anxiety in Denmark. *BMC Psychol* 2022;10:70.
85 Hodgson E, Stuart JR, Train C, *et al*. A Qualitative Study of an Employment Scheme for Mentors with Lived Experience of Offending Within a Multi-Agency Mental Health Project for Excluded Young People. *J Behav Health Serv Res* 2019;46:140–50.
86 Haft SL, Martinez W. The Clinician's Role in Youth Peer Support Services for Mental Health. *J Health Serv Psychol* 2025;51:117–27.
87 Burke EM, Pyle M, Machin K, *et al*. Providing mental health peer support 1: A Delphi study to develop consensus on the essential components, costs, benefits, barriers and facilitators. *Int J Soc Psychiatry* 2018;64:799–812.
88 Burke EM, Pyle M, Machin K, *et al*. Providing mental health peer support 2: Relationships with empowerment, hope, recovery, quality of life and internalised stigma. *Int J Soc Psychiatry* 2018;64:745–55.
89 Gillard S, Holley J, Gibson S, *et al*. Introducing New Peer Worker Roles into Mental Health Services in England: Comparative Case Study Research Across a Range of Organisational Contexts. *Adm Policy Ment Health* 2015;42:682–94.
90 Armenti K, Sweeney M, Lingwall C, *et al*. Work: A Social Determinant of Health Worth Capturing. *IJERPH* 2023;20:1199.
91 Rugulies R, Aust B, Greiner BA, *et al*. Work-related causes of mental health conditions and interventions for their improvement in workplaces. *The Lancet* 2023;402:1368–81.
92 Ahmed AO, Hunter KM, Mabe AP, *et al*. The Professional Experiences of Peer Specialists in the Georgia Mental Health Consumer Network. *Community Ment Health J* 2015;51:424–36.
93 Llosa-Fernández JA, Menéndez-Espina S, Agulló-Tomás E, *et al*. Incertidumbre laboral y salud mental: una revisión meta-analítica de las consecuencias del trabajo precario en trastornos mentales. *AN PSICOL-SPAIN* 2018;34:211.
94 LaMontagne AD, Martin A, Page KM. Developing an integrated approach to workplace mental health. In: Hudson HL, Nigam JAS, Sauter SL, *et al*., eds. *Total worker health*. Washington, DC: American Psychological Association, 2019: 211–27. Available: http://content.apa.org/books/16125-000
95 Watson B, Osberg L. Job insecurity and mental health in Canada. *Appl Econ* 2018;50:4137–52.
96 Kalleberg AL. Precarious Work, Insecure Workers: Employment Relations in Transition. *Am Sociol Rev* 2009;74:1–22.
97 Raphael D, Bryant T, Mikkonen J, *et al*. Social determinants of health: the canadian facts [online]. 2020. Available: https://thecanadianfacts.org/ [Accessed 4 Oct 2024].

98 Corrigan P. Beware the Educational Fix: Limitations of Efforts to Promote Mental Health Literacy. *PS* 2018;69:469–71.
99 Halsall T, Orpana H, Jan M. Tracing the undercurrents: a scoping review of the lifestyle drift concept. *BMC Public Health* 2025;26:321.
100 Kastner M, Bhattacharyya O, Hayden L, *et al*. Guideline uptake is influenced by six implementability domains for creating and communicating guidelines: a realist review. *J Clin Epidemiol* 2015;68:498–509.
101 Brouwers MC, Spithoff K, Lavis J, *et al*. What to do with all the AGREEs? The AGREE portfolio of tools to support the guideline enterprise. *J Clin Epidemiol* 2020;125:191–7.
102 Labonté R. Health Promotion in an Age of Normative Equity and Rampant Inequality. *Int J Health Policy Manag* 2016;5:675–82.
103 Statistics Canada. Distributions of household economic accounts for income, consumption, saving and wealth of canadian households, second quarter 2024 [The Daily]. 2024. Available: https://www150.statcan.gc.ca/n1/daily-quotidien/241010/dq241010a-eng.htm
104 Mills C. The Psychiatrization of Poverty: Rethinking the Mental Health–Poverty Nexus. *Social & Personality Psych* 2015;9:213–22.
105 Sylvestre J, Notten G, Kerman N, *et al*. Poverty and Serious Mental Illness: Toward Action on a Seemingly Intractable Problem. *American J of Comm Psychol* 2018;61:153–65.