



For Public Release

# Engagement Report – Mental Health Peer Support

Department of Opportunities and Social Development  
Office of Addictions and Mental Health

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# Engagement Approach & Methodologies



# Engagement Approach | Summary Report

## How to use this document?

This document summarizes **what we heard through engagements** conducted as part of the disability-focused mental health peer support project. It reflects input gathered from **system partners, community-based mental health organizations, first voice, DSP staff and service providers, and organizations delivering Peer Support** across Nova Scotia.

The report presents **key themes, patterns, and insights** identified **through thematic analysis of interviews, focus groups, and surveys**. Findings are organized to highlight shared experiences, access barriers, service gaps, and design considerations **relevant to a disability-focused peer support model**.

This document is intended to:

- Provide **transparent, participant-informed insight** into current realities
- Support **shared understanding across partners**
- Inform subsequent **design, feasibility, and implementation planning**

## Engagement Considerations

Engagement findings are presented to support **accessibility, accountability, and meaningful use of participant input** in future phases of this work.

The following notes provide context on how engagement findings should be read, interpreted, and used:

- Engagement findings **reflect patterns across voices**, and individual perspectives can be highlighted throughout
- Insights are **descriptive, not prescriptive**—they do not validate a final service model or represent implementation decisions
- Themes should be read as inputs to design, **alongside literature, jurisdictional scans, and current state considerations** summarized in the research report



# Engagement Approach | Methodologies

The following methods served as the primary approaches for engagement and information gathering throughout the Discovery phase of the disability-focused mental health peer support initiative. Collectively, they aimed to capture diverse perspectives to assess the need for peer support, identify gaps in existing services, and inform key feasibility considerations.



## Virtual Focus Groups

- Facilitated group discussions designed to surface shared experiences, access barriers, and unmet needs
- Supported collective reflection and dialogue while allowing participants to build on one another's perspectives
- Offered virtually to reduce barriers related to geography, mobility, transportation, and scheduling



## Targeted Interviews

- One-on-one conversations designed to explore experiences and perspectives in greater depth
- Used to understand service pathways, system realities, risks, and feasibility considerations
- **Delivered in person or virtually, based on accessibility needs and participant preference**



## Short Surveys

- Short, plain-language survey with a small number of focused questions
- Designed to quickly identify priority needs, access challenges, and common patterns
- Delivered online and in accessible formats, with optional open-ended responses



# Engagement Approach | Engaged Audiences

Engagements were conducted with individuals across **all regions of Nova Scotia**, ensuring geographic diversity and representation of both urban and rural perspectives. In addition to primary engagements, this work **leveraged relevant insights from the Peer Supported Planning Project and the Fit Gap Project**. Both initiatives included engagement with **community-based organizations, system partners, and people with lived experience (First Voice)**, and their findings were used to strengthen and contextualize analysis for this project.

Engagement Audience	Purpose of Engagement	Method(s)	Format	Participants / Responses
People with lived experience (First Voice)	Understand lived experience of access, navigation, trust, and unmet mental health needs	Semi-structured interviews	1:1 in person	12 participants
Disability Service Providers	Identify service gaps, access barriers, and system feasibility considerations	Short survey	Online, accessible formats	49 responses
Community-based mental health organizations	Understand current peer support delivery, system integration, and capacity considerations	Focus groups, interviews	Virtual	3 sessions
DSP Staff (IPSC/LAC team leads, care coordinators)	Explore operational realities, navigation challenges, and transition points	Focus groups	Virtual	2 sessions
System partners (OAMH, OSD, NSH, IWK)	Assess system alignment, integration risks, and implementation considerations	Focus groups, interviews	Virtual / in-person	9 sessions
Remedy expert	Ground findings in Remedy context and implementation considerations	Interview	1:1 virtual	1 participant
Peer support delivery organizations	Understand peer workforce models, training, boundaries, and sustainability	Focus groups, interviews	Virtual	2 sessions



# Analysis & Pattern Identification



# Engagement Analysis | Thematic Analysis

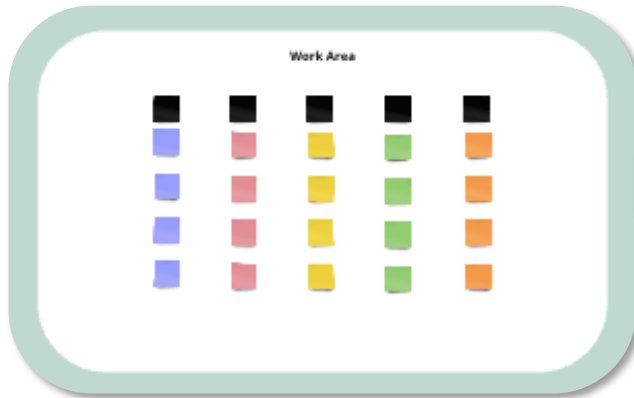
Engagement input was compiled and analyzed using thematic analysis **to identify shared experiences, service gaps, and priority considerations**. Insights were synthesized across interviews, focus groups, and surveys, with **observations organized into themes and examined for patterns and relationships**. The findings are presented in this report as a consolidated “**What We Heard**” summary to support transparency, shared understanding, and future design work.

## Inputs:

Focus Groups   Surveys   Interviews

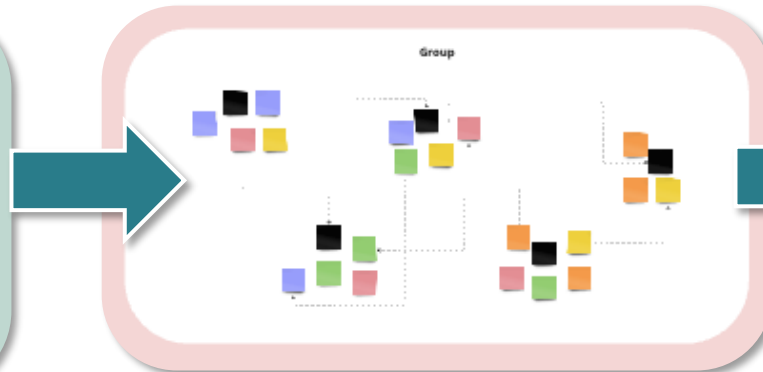
## Observations

*What people say*



## Relationships

*Finding commonalities and opportunities*



## Insights

*Deriving meaning*



**Engagement Report**

**External  
'What We Heard'  
Report**



# Engagement Analysis | Patterns & Theme Identification

The thematic analysis revealed several **patterns**, resulting in the **identification of themes** that represent the insights gathered from the engagements. This report is structured around **six (6) main themes** that capture the collected data and provide further context for the analysis findings.

1

## Access & Eligibility



Access & Eligibility refers to the ways people with disabilities are able or unable to reach and qualify for mental health and peer support services. This theme captures how access pathways, eligibility criteria, geography, transportation, service modalities, and system constraints interact to either enable or block meaningful entry into support.

2

## Navigation & Continuity



Navigation & Continuity describes how people move through mental health and disability systems over time, including their ability to understand pathways, transition between services, and maintain consistent support relationships. This theme focuses on what happens after entry into the system and whether care is sustained, coordinated, and relational.

3

## Lived Experience & Trust



Lived Experience & Trust centers how trust is built or eroded through people's past interactions with systems and services, and how lived experience can inform more responsive, respectful, and recovery-oriented peer support. This theme emphasizes relational safety, credibility, and shared understanding.

4

## Workforce & Sustainability



Workforce & Sustainability examines the conditions required to support peer support as skilled, ethical, and durable work. This theme focuses on the structures, resources, and safeguards needed to recruit, train, support, and retain peer supporters over time.

5

## Equity, Accessibility & Safety



Equity, Accessibility & Safety refers to the extent to which peer support is designed to be inclusive, trauma-informed, and safe for diverse participants across disability, culture, geography, and communication needs. This theme emphasizes universal design, safeguarding, and harm prevention.

6

## Peer Support Model Fit



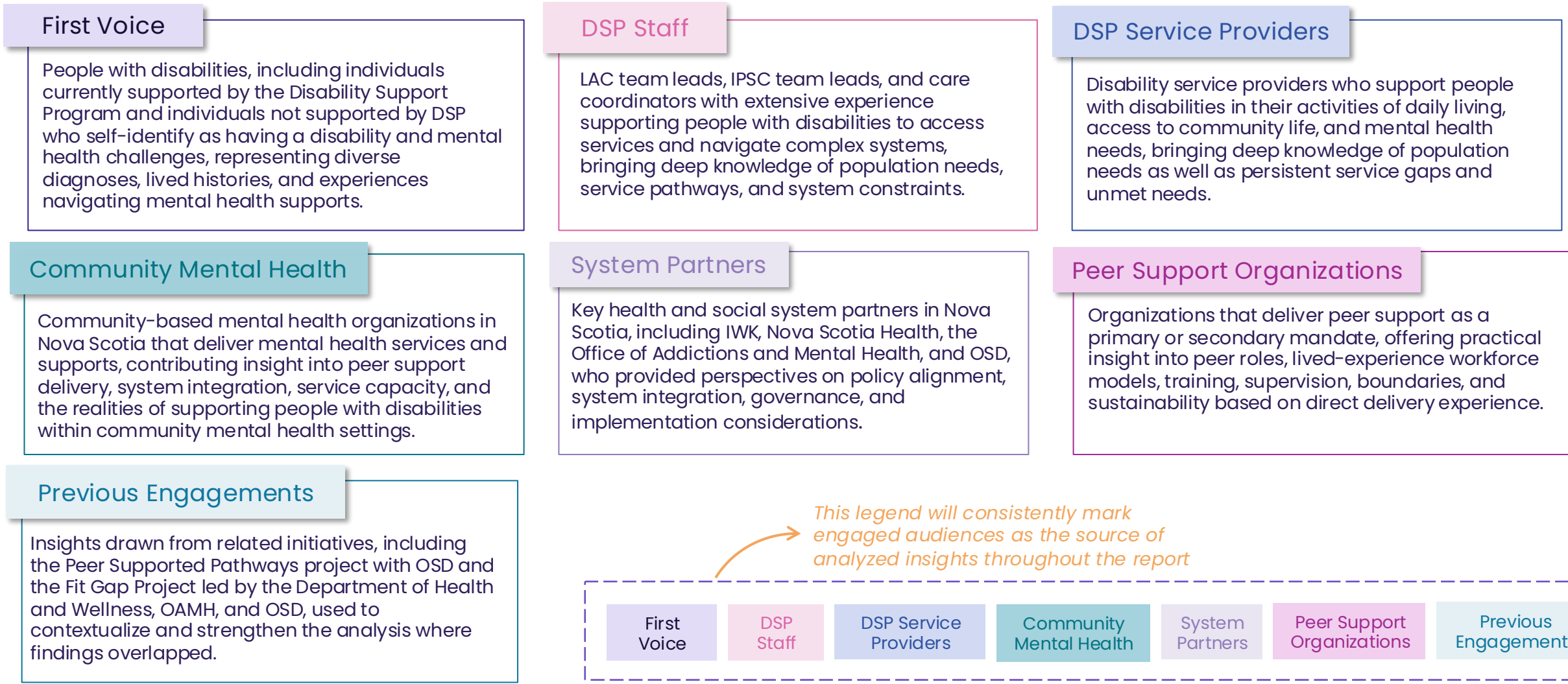
Peer Support Model Fit examines how well peer support aligns with the needs, goals, and realities of people with disabilities and the broader mental health system. This theme focuses on where peer support is most effective, how it complements clinical services, and the conditions under which it adds the most value.



# Engagement Analysis | Audience & Theme Identification

Various audience groups were engaged according to their **impact**, **experience with**, and **participation in** peer support across the ecosystem.

The following audiences are **identified throughout the report** to identify the **source** of the analyzed insights.







# Access & Eligibility

## **Sub-sections:**

- Entry Processes
- Eligibility Criteria
- Geography, Transportation, & Service Modalities
- System Constraints and Limited Choice



# Entry Processes

## Entry processes function as a gateway to mental health services, but also as a barrier

Access pathways were described as the primary entry to mental health services for individuals with disabilities, but also as a **significant access barrier**. Telephone-based entry does not work well for everyone, particularly some people with disabilities, and alternative formats (e.g., video, in-person) are not always accessible or easy to arrange.

Mental health system partners noted that a substantial portion of initial contacts are focused on **navigation rather than treatment**, highlighting the importance of relational, ongoing support beyond initial access. DSP staff and community organizations also noted that **rigid access models** prioritize diagnosis and service fit over functional, social, and well-being needs.

There was caution raised that **introducing peer support at contact** could be perceived as a “lesser” service if the individual is seeking clinical therapy and services, reinforcing the importance of clear positioning and communication about the role and scope of peer support as a mental health service.

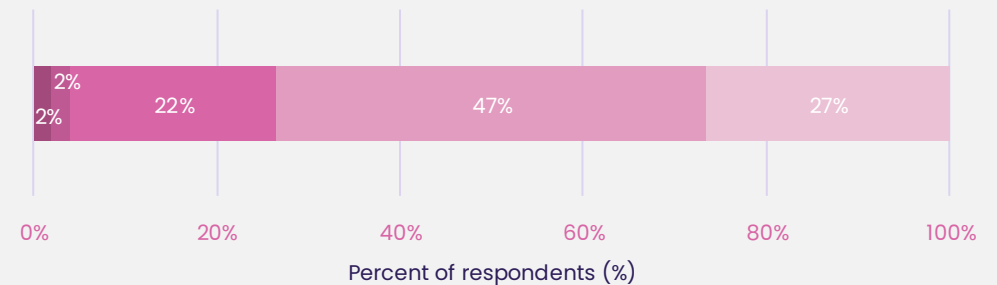


### Key Takeaway

- Standardized entry processes often **do not accommodate** diverse communication styles, cognitive needs, or support requirements.
- Complex & rigid access structures **discourage engagement** and can delay access to care.

### Q7: How easy is it for people you support to find and access supports that respond to their mental-health related needs?

■ Very easy      ■ Somewhat easy      ■ Neither easy nor difficult  
■ Somewhat difficult      ■ Very difficult



Source: DSP Service Provider Survey

Context: This question highlights the difficulty many individuals with disabilities and mental health challenges face when **attempting to find and access mental health supports**, with most respondents selecting either **very difficult (27%)** or **somewhat difficult (47%)**.



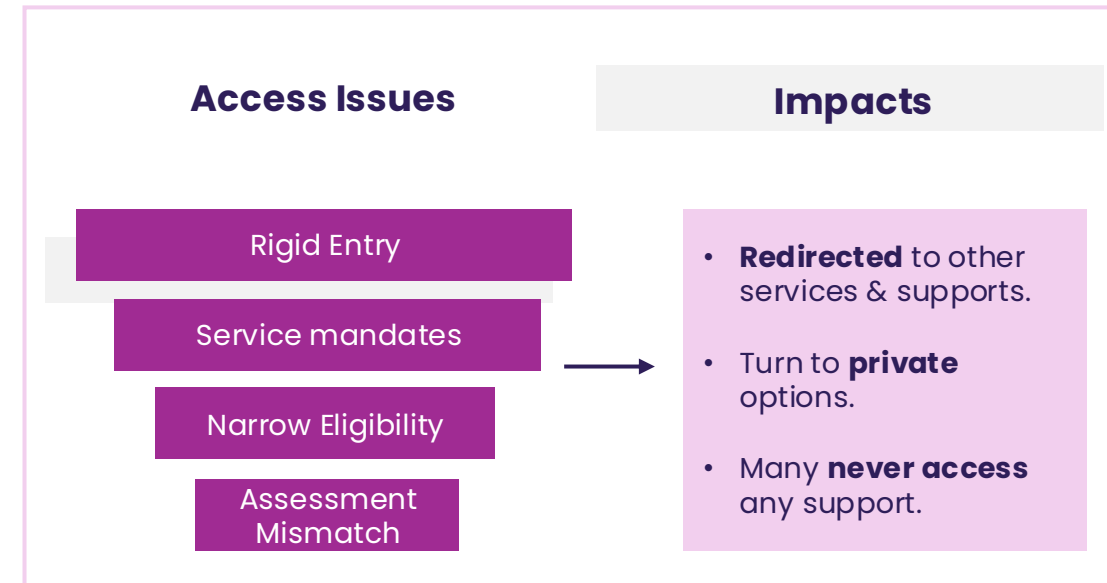
# Eligibility Criteria

## Eligibility rules and diagnosis-driven service mandates exclude many people with disabilities

Across mental health system partners, DSP staff, community organizations, and First Voice participants, people with disabilities are frequently deemed **ineligible for mainstream mental health services** or declined due to eligibility criteria, diagnosis-driven service thresholds, or program mandates. Respondents described people with disabilities being redirected between systems (mental health & disability) without their needs being met, resulting in fragmented access and limited accountability.

**Eligibility barriers are particularly acute for people with intellectual disabilities.** Access to mental health services is often **tied to standard assessments, diagnostic tools, and treatment pathways** that are **not designed or adapted** for different communication styles, cognitive abilities, or lived experiences. This contributes to misdiagnosis risk, inappropriate treatment, or service refusal.

When publicly funded services are inaccessible, many individuals with disabilities turn to **private mental health care and services**, often without adequate support to navigate options or cover costs, exacerbating inequities related to income, geography, and family support.



## Key Takeaway

**Narrow eligibility criteria** and **diagnostic requirements** often result in people with disabilities being deemed ineligible for mental health services.



# Geography, Transportation, & Service Modalities

## Geography, transportation, and modality significantly shape access

**Geography and transportation** were consistently identified as **major access barriers**. While some specialized services may have capacity, they are often **not accessible province-wide**, particularly for people living in rural or remote communities where supports are concentrated in larger centres.

**Transportation barriers** were frequently raised by First Voice participants and peer organizations. Individuals who do not drive and rely on family, paid supports, or limited public transit often **require additional planning, funding, or logistical coordination** to participate.

These challenges are intensified in rural areas with greater travel distances and fewer options.

Rural access barriers are compounded beyond distance alone. Participants highlighted **limited local services, poor internet or cell coverage, and economic constraints** as additional factors that restrict in-person and virtual access for rural residents.

Virtual services can improve access, particularly for people without transportation or competing responsibilities.

However, respondents emphasized that virtual supports are most effective when **optional, supported**, and used to **complement in-person services**.



## Key Takeaway

- Geography & transportation barriers shape access, particularly for **people in rural or remote areas**.
- Virtual services can improve access when implemented well, but are most effective when **optional, supported**, and **complement in-person care**.



# System Constraints and Limited Choice

## Wait times, capacity constraints, and cost limit meaningful access

**Long wait times and limited service availability were identified as primary barriers across audiences.** Delays can worsen symptoms and increase **reliance on crisis-driven care** (e.g., ER or hospitalization), placing strain on individuals and the mental health system.

Economic insecurity further constrains access to mental health supports, particularly when services require private payment. While removing or reducing fees can improve participation, some community organizations emphasized the need to **balance low-barrier access with program sustainability**. Peer support organizations also noted that access is constrained by capacity, transportation, rurality, and communication needs, reinforcing the need for flexible delivery models.

First Voice participants consistently emphasized that limited choice, in providers, settings, timing, format, and duration of support, reduces engagement and contributes to feelings of disempowerment and harm. Some individuals described a potential peer support program as **their only remaining option** for mental health support, not because it was preferred, but **because other services were inaccessible**.



- Wait times, capacity constraints, and cost **limit meaningful access** and contribute to reliance on crisis-driven care
- Limited choice in **providers, settings, timing, and format** reduces autonomy, engagement

## Audience Highlight *First Voice*

First voice participants highlighted that having choice over **how, when, and where support is delivered** improves perceived quality of care, engagement, and sustainability of support.



## Research Highlight *Peer Support as Complementary*

The literature consistently positions **peer support as a complementary non-clinical component of mental health systems**.

Integration is beneficial when it **preserves the peer support identity** and avoids role drift into clinical functions.



# Navigation & Continuity

## **Sub-sections:**

- Standard Service Model Limitations
- Individual Navigation Difficulties
- Transitioning Between Supports
- Fragmentation and System Visibility
- Importance of Consistent Relationships
- Peer Support Opportunity



# Standard Service Model Limitations

## Standard, time-limited service models do not support continuity of care

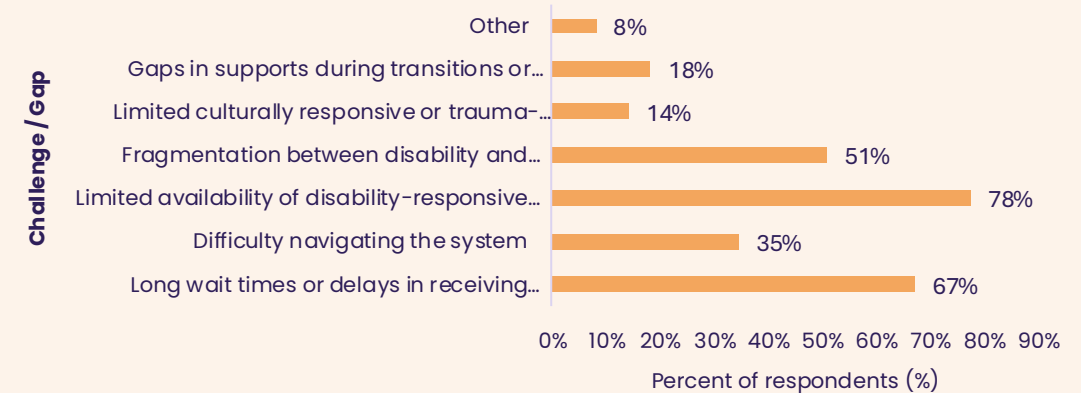
Engagement participants consistently described mental health service models that are structured around fixed, time-limited interactions (E.g., initial access followed by short appointments with long gaps between sessions), which do **not align with the ongoing and fluctuating needs** of many people with disabilities.

These models often result in **extended periods without support**, during which individuals may experience deterioration, disengagement, or increased distress.

System partners and DSP staff noted that **long wait cycles** and **inflexible scheduling** exclude people who require responsive or continuous support, contributing to repeated breaks in care.

Community-based mental health organizations further emphasized that while individuals may temporarily stabilize during time-limited services, the **absence of follow-up or maintenance supports** often leads to **re-entry into crisis situations, reinforcing a reactive rather than preventative mental health system**.

## Q5: What challenges or gaps do you most commonly see?



Source: Service Provider Survey

Context: One of the most common challenges identified by service providers was **long wait times or delays in receiving support (67%)**, suggesting that individuals with disabilities seeking mental health supports often experience gaps in care that undermine continuity and timely intervention.



## Identified Service Gaps & Unmet Needs Time-bound Care

It was commonly noted that despite gaining access to the mental health system, **extended waiting periods** and **short treatment durations** limit effective assistance, frequently aggravating conditions and causing avoidable emergencies. This situation also undermines trust in existing services, highlighting the necessity for ongoing and sustained care options.



# Individual Navigation Difficulties

## Navigation is treated as an individual responsibility rather than a supported function

Across engagements, navigation of the mental health system was described as something individuals are largely **expected to manage on their own**, even though pathways are complex, fragmented, and difficult to understand.

DSP staff and service providers noted that while some people are referred to mental health supports by healthcare professionals, **many must independently identify services, complete referrals, and navigate access processes** without consistent assistance.

First Voice participants described how navigating referrals, paperwork, and unclear service pathways can be **overwhelming** and **discouraging**, particularly after repeated unsuccessful attempts to access support.

While receiving basic information about available services can help with initial orientation, first voice participants emphasized that **information alone** does not ensure **meaningful fit or sustained engagement**, especially when relational understanding of their experiences and feelings and ongoing guidance are absent.

## Audience Highlight *First Voice*

First Voice participants described **difficulties knowing where to go next** when attempting to access mental health services.



## Identified Service Gaps & Unmet Needs *Unsupported System Navigation*

It was frequently emphasized that individuals **do not know where to go to find the available and best options for support**, often leading to feelings of **struggle** and **overwhelmingness** while trying to navigate the **current mental health system**.



# Transitioning Between Supports

## Transitions are high-risk points where continuity breaks down

Transitions were consistently identified as some of the most tenuous moments within the mental health and disability support systems.

Participants highlighted transitions such as **inpatient to community care, youth to adult services, supportive housing to independent living, and early intervention to longer-term community supports** as periods when continuity of care frequently deteriorates.

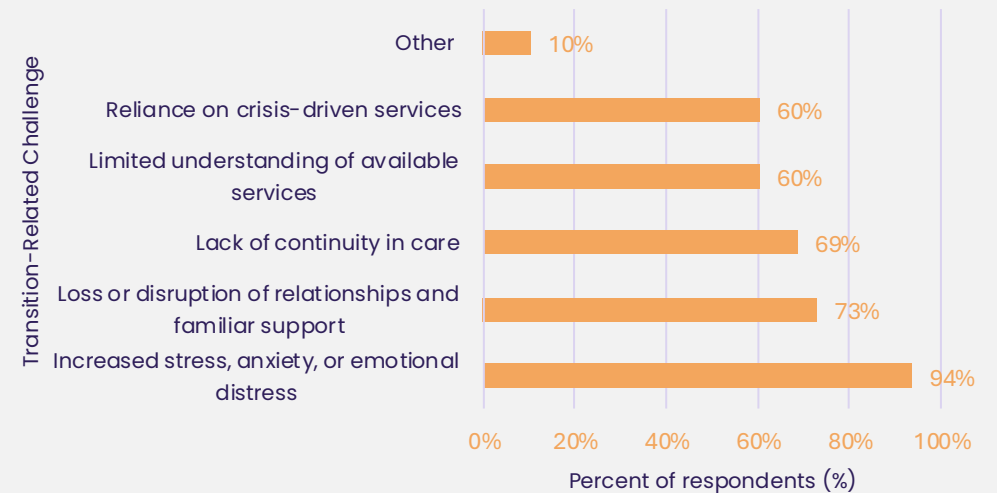
During these transitions, individuals may lose trusted relationships, experience disruption to routines, and face uncertainty about where to access support next.

System partners noted that when transitions are not well supported, **individuals may interpret them as the end of mental health care altogether**, contributing to disengagement and, in some cases, repeated hospitalizations due to lack of timely community-based follow-up.

### Key Takeaway

Transitions between services are **moments of heightened risk**, where loss of relationships and unclear next steps frequently result in disengagement and repeated hospitalizations.

## Q8: During transitions into community, what mental health-related challenges are most common?



Source: Service Provider Survey

Context: This question highlights the mental health-related challenges individuals with disabilities face when transitioning into the community. As **more individuals transition into community settings from institutions** in the coming years, in alignment with the Remedy, appropriate supports will need to be in place to ensure continuity and stability during these transitions.



# Fragmentation & System Visibility

## Fragmentation and limited service visibility complicate navigation

Participants described a mental health system with **many services operating in parallel** but **limited coordination** between them. System partners noted that individuals are often required to be aware of multiple pathways and programs, yet there are few connectors to help people move between services effectively. In urban areas, such as Halifax, **lack of awareness of community-based services** was identified as a particular challenges, with many people accessing hospital-based care directly rather than community supports.

This lack was visibility was attributed to factors such as the size of the city, limited referral knowledge among healthcare professionals, social disconnection, and stigma that causes some services to remain "hidden".

Several participants suggested that **perceived service gaps reflect navigation, resourcing, or coordination challenges** rather than the absence of services, highlighting the importance of improving visibility and accessibility of existing supports.

### Navigating System Options



Disability Organizations & DSP

Community Mental Health Programs

Youth Mental Health Services

Adult Mental Health Services

Crisis & Emergency Services

Addiction Services



## Key Takeaway

Multiple parallel pathways exist, but **limited coordination** and **visibility** make it difficult for individuals and providers to navigate services effectively, particularly in urban settings.



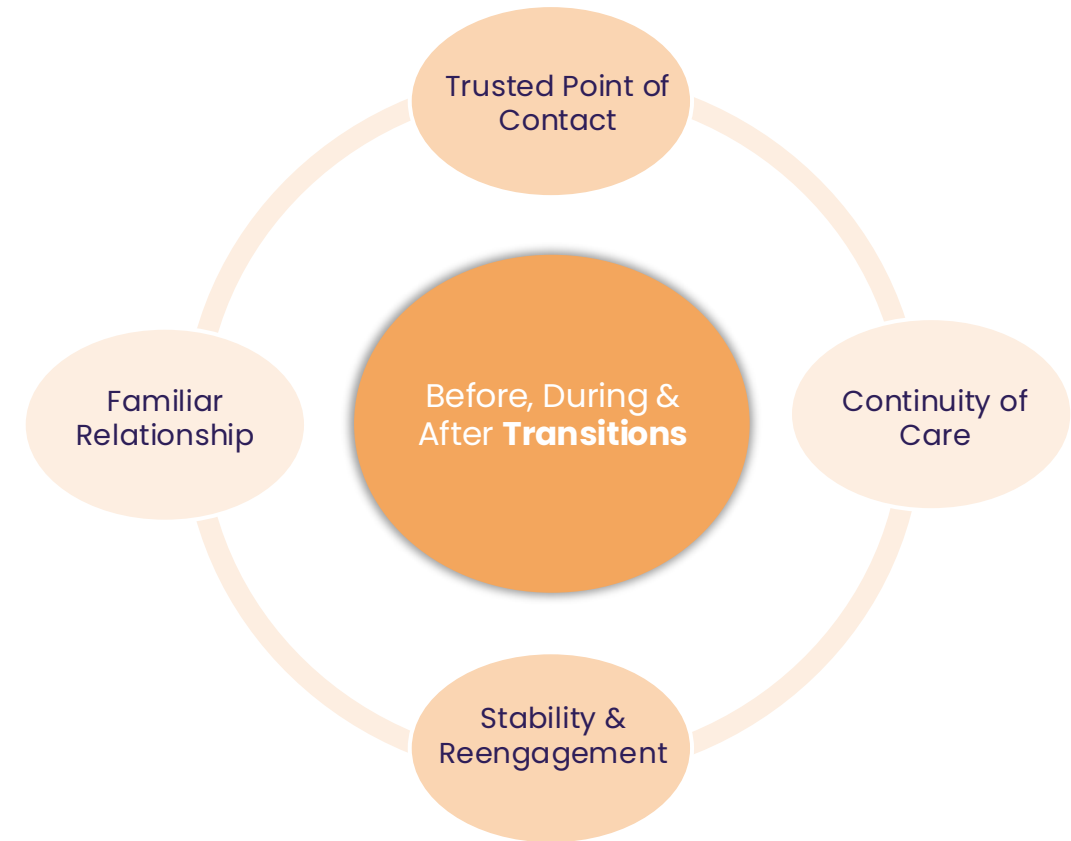
# Importance of Consistent Relationships

## Consistent relationships are central to successful continuity

Across different respondent groups, continuity was most strongly associated with the **presence of consistent, trusted relationships**.

DSP staff and disability service providers emphasized that people are more likely to navigate mental health systems successfully when they have **familiar points of contact** who understand their history, needs, and circumstances. Continuity of relationships before, during, and after transitions was viewed as critical to maintain engagement and reducing stress.

First Voice participants similarly emphasized the importance of **knowing who to contact** when support is needed, noting that clear points of connection reduce barriers and increase the likelihood of seeking help. In the absence of consistent relationships, individuals may struggle to re-engage with services, particularly during periods of change or instability.



### Research Highlight

*Lasting Connections for Support Success*

Continuity in peer programs has been supported by **clear transition points** and **ongoing formats** that foster lasting connections, which are **key for effective peer support**.

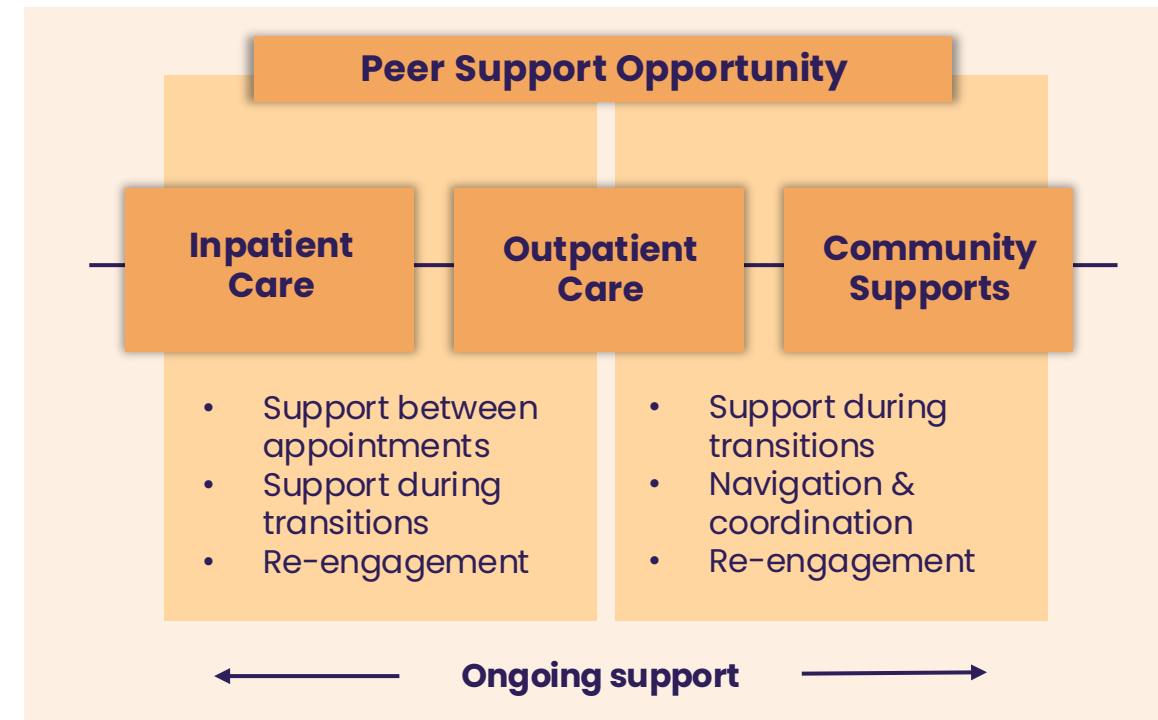


# Peer Support Opportunity

## Peer support is viewed as a mechanism to bridge navigation and continuity gaps

Peer support was consistently identified as a potential mechanism to **address navigation and continuity gaps** across the system. Participants described how peer support could provide **flexible, informal check-ins** between clinical appointments, assist with system navigation, and normalize ongoing engagement with supports over time. Peer support was seen as **particularly valuable during transitions**, such as discharge from inpatient care, movement between youth and adult mental health systems, and reconnection with community and natural supports.

System partners and peer support organizations emphasized that peer support roles would need to be **clearly defined and well integrated** with clinical services to allow for timely escalation during crises while maintain non-clinical boundaries. Peer support relationships were described as scalable rather than permanent, with the **goal of building independence** and **strengthening natural supports** rather than replacing formal services.



## Key Takeaway

Peer support is viewed as a **flexible, relational way** to **support navigation and continuity** across gaps between appointments and during transitions, where formal systems fall away





# Lived Experience & Trust

## **Sub-sections:**

- Building Trust for Better Engagement
- Shared Experiences Improve Sense of Safety
- Peer Support Matching Criteria
- Choice as a Source of Empowerment
- Importance of Confidentiality and Boundaries
- Impact of the Location of Peer Support
- Reciprocal Peer Support

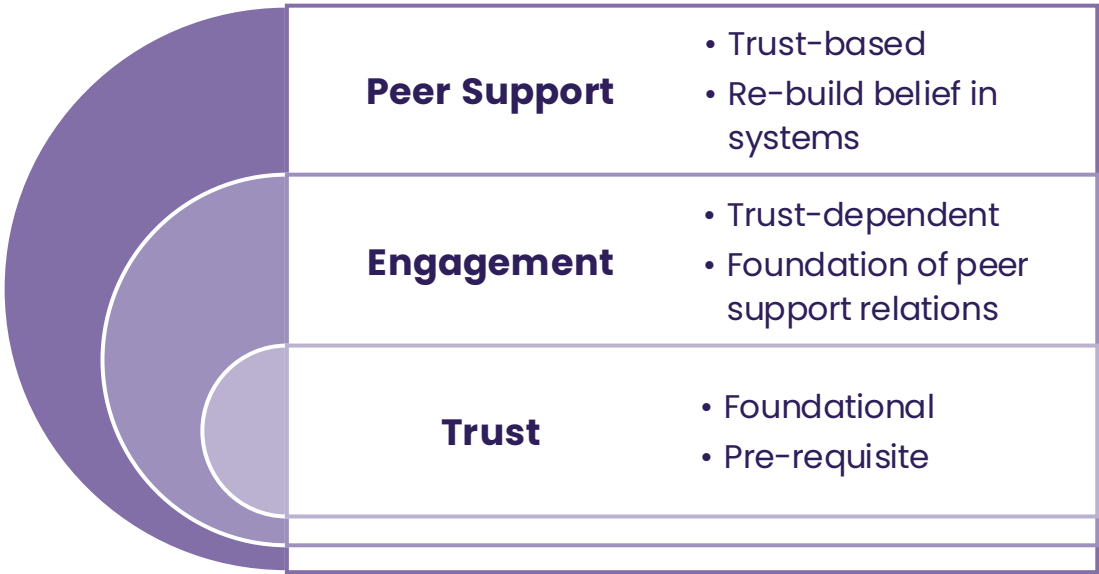


# Building Trust for Better Engagement

## Trust Is Precondition for Engagement and Supportive Relations

First Voice participants emphasized **that trust is a prerequisite for engagement**, not a secondary benefit. Many described that without trust, they simply disengage from supports altogether.

System partners acknowledged that **trust has been significantly damaged for people with disabilities** through past mental health system interactions and noted that peer support may help rebuild trust where clinical systems have failed.



### Research Highlight

#### *Relational and Trust-based Support*

Peer support is defined as an engagement-driven relationship where **trust, credibility, and shared context** build the foundation of support—particularly for people with disabilities and mental health needs



# Shared Experiences Improve Sense of Safety

## Shared Lived Experience Is Central to Feeling Safe and Understood

First Voice participants emphasized that peer support feels credible and safe specifically because it is **grounded in shared lived experience, rather than professional or clinical expertise.**

DSP staff emphasized that **lived experience enables peer supporters to connect in ways service providers cannot**, particularly by reducing power imbalances and feelings of being judged.

Community-based mental health organizations emphasized that **peer support offers a fundamentally different value proposition** than standardized clinical care, rooted in mutual understanding, compassion, and relatability.



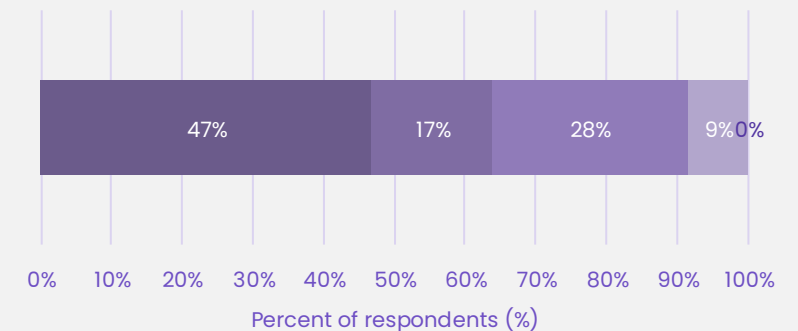
### Research Highlight *Impacts of Lived Experience*

Evidence as shown that peer support companionship and bi-directional relationships grounded in **shared lived experience** help **reduce isolation** and **foster hope**

Q13: Please rate the **importance of peer support workers having experience in the following areas:**

### Disability & Mental Health Challenges

■ Extremely Important ■ Very Important  
■ Moderately Important ■ Slightly Important  
■ Not Important



Source: DSP Service Provider Survey

Context: This question asked providers the importance of peer supporters having experience in disability, mental health, or disability and mental health challenges. The results demonstrate a **strong consensus** regarding the **importance of lived experience** among peer supporters, with the highest level of importance placed on peers having **both disability and mental health challenges.**



# Peer Support Matching Criteria

## Matching (and Re-Matching) Is a Core Trust-Building Mechanism

First Voice participants emphasized that **trust depends heavily on good relational fit**, including shared experience, communication style, comfort, and chemistry.

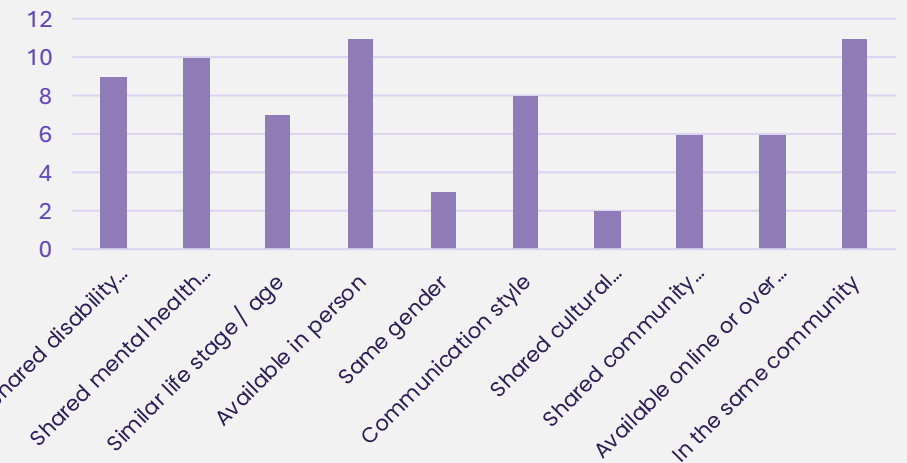
Community-based mental health organizations emphasized that **matching should be treated as a core design feature**, not an administrative task, and that **re-matching must be normalized** when fit is not right.

Peer support organizations emphasized that **emotional resonance and participant choice matter more than identical diagnoses**, and that poor matching can undermine trust quickly.

### Audience Highlight First Voice

Participants highlighted that repeatedly **re-telling** personal experiences and needing to **justify distress** contributes to exhaustion and reluctance to seek help, indicating that appropriate peer support matching processes could help reduce these experiences by building trust overtime.

## Preferred Matching Criteria



**Note:** One respondent wrote “no” for this question on their workbook, so they are counted as selecting none.

Source: First Voice Engagement Results

Context: The peer matching results indicate that First Voice participants prioritize **local, accessible, and experience-based connections** when considering how peer support matching should be structured. Most respondents **identified in-person availability (11 of 12)** and being in **the same community (11 of 12)** as essential matching criteria, highlighting the importance of geographically based support.



# Choice as a Source of Empowerment

## Choice, Control, and Consent are Central to Trust

First Voice participants emphasized that **having choice over whether, how, when, and with whom support** occurs directly affects whether support feels safe or harmful.

First Voice participants also emphasized that **lack of choice** in providers, format, or duration contributes to **feelings of disempowerment**, particularly for people with lifelong experiences of having decisions made for them.

Mental Health system partners emphasized the importance of **supported decision-making** and explicit consent, noting that **standard mental health approaches often fail** to reflect the lived experiences of people with disabilities.

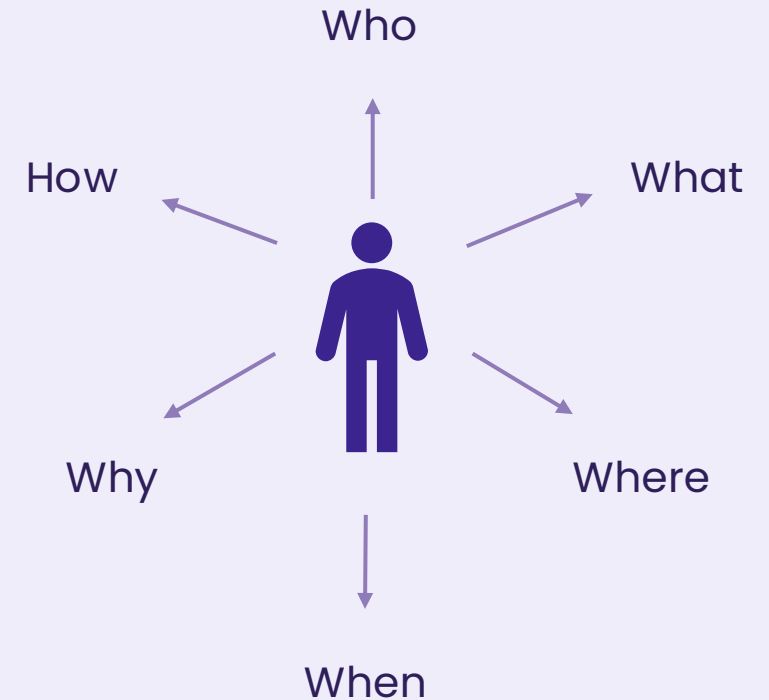


### Research Highlight

#### *Self-determination as Core Value*

One of the identified core values of peer support is **self-determination** – affirming that individuals direct their own recovery, set their own goals, and make their own decisions

## Centering Participant Choice





# Importance of Confidentiality and Boundaries

## Confidentiality and Clear Boundaries Are Non-Negotiable

First Voice participants emphasized that **strict confidentiality is essential for trust**, especially in small communities or online settings where fear of information sharing is high.

Community-based mental health organizations emphasized that **poorly governed or informal peer spaces pose real safety risks**, and that trust depends on clear boundaries, safeguards, and oversight.

Mental health system partners cautioned that **peer support models without adequate structure and monitoring can unintentionally cause harm**, even when intentions are positive.



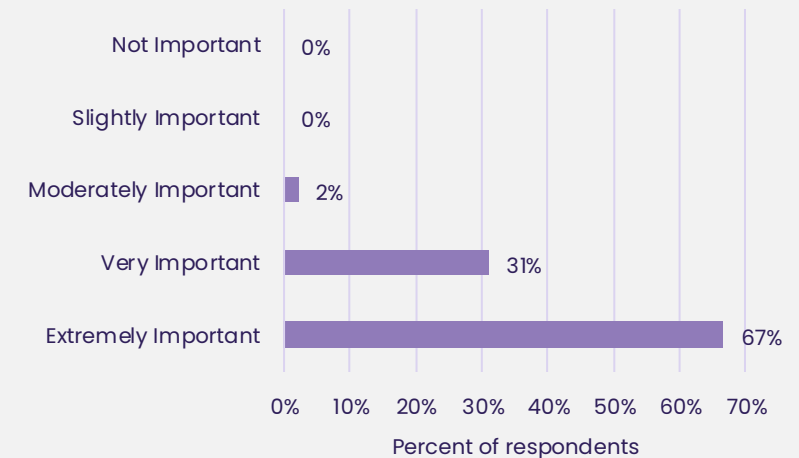
### Research Highlight

#### Peer Support Standards of Practice

**Ethical responsibilities** integrate the code of conduct of peer support – ensuring safety, respect, boundaries, integrity, and non-judgmental peer support practice.

## Q14: Please rate the importance of each of the following design considerations for a disability-focused peer support model:

### Boundaries & Scope of Practice



Source: DSP Service Provider Survey

Context: The majority of respondents ranked boundaries and scope of practice as being **very or extremely important**. These findings overlap with many qualitative survey responses, which **caution against informal or poorly defined peer roles** and emphasize the **risks associated with unclear boundaries**.



# Impact of the Location of Peer Support

## Environment and Program Location Shape Trust

First Voice participants emphasized that **non-clinical, calm, and familiar environments feel safer and more trustworthy** than formal mental health settings.

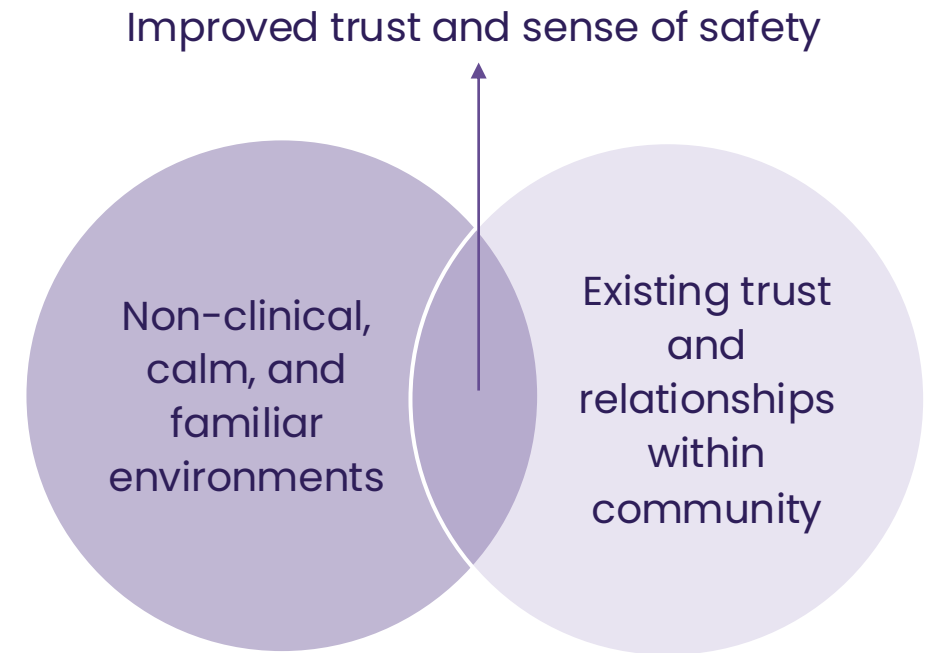
Mental health system partners emphasized that **where peer support “sits” organizationally affects how it is perceived**, noting that mental health branding can deter people seeking disability-related support.

Community-based mental health organizations emphasized that **community-embedded delivery builds on existing trust and relationships**, making engagement more likely.



### Identified Service Gaps & Unmet Needs Peer Support Program Integration

Peer support can enhance continuity and navigation when coordinated with **clinical and disability systems**. However, **integration** is only beneficial when the peer role remains clearly defined, non-clinical, and protected from role drift. Maintaining peer identity is critical to program credibility and safety.





# Reciprocal Peer Support

## Peer Support Is Valued as a Relationship, Not a Service

First Voice participants emphasized that **peer support is most valuable when it feels relational rather than transactional**, centered on being listened to, taken seriously, and understood.

First Voice participants also emphasized **the importance of reciprocity**, describing peer support as a space **where people can both receive and offer support**, which supports dignity and belonging.

Community-based mental health organizations emphasized that peer relationships are **most effective when they are goal-based rather than strictly time-limited**, with shared understanding of purpose and closure.

### Peer support as a reciprocal relationship



### Audience Highlight *DSP Staff*

DSP staff emphasized peer support's role in reducing isolation and helping people feel less alone, particularly during transitions or periods of vulnerability.





# Workforce & Sustainability

## **Sub-sections:**

- Workforce Sustainability and Wellbeing
- Requirements for Peer Workers Safeguards
- Workforce Infrastructure and Program Sustainability
- Funding and Program Stability
- Challenges to Continuity of Support



# Workforce Sustainability and Wellbeing

## Peer Support Is Skilled and Demanding Work & Worker Wellbeing Is a Safety Issue

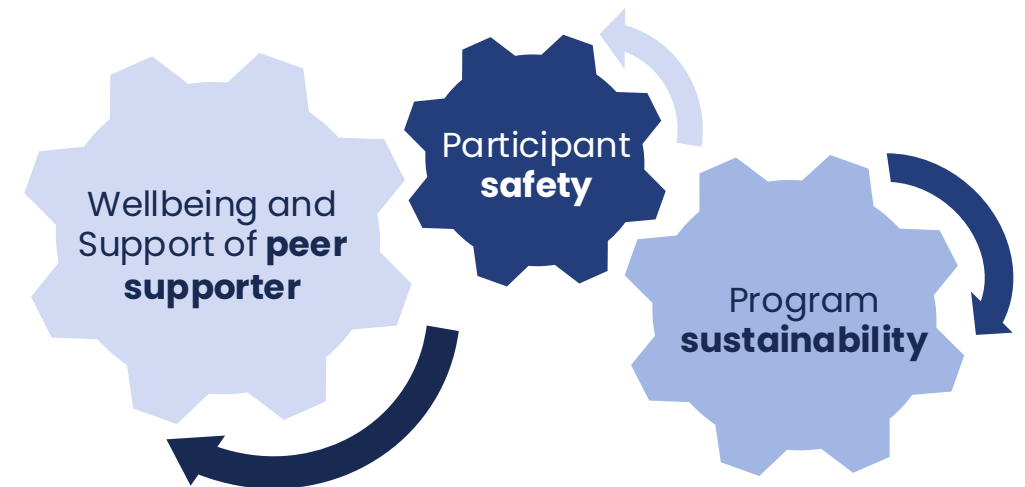
Peer support organizations, community-based mental health organizations, and DSP staff consistently emphasized that **peer support is skilled, emotionally demanding work – not informal or volunteer activity.**

Community-based mental health organizations emphasized that **peer supporters must be paid, properly supported, and retained as part of an ethical workforce model**, noting that peer roles include emotional labor, coordination, and responsibility beyond direct service.

Peer support organizations and community-based organizations emphasized that **readiness** and stability of lived experience must be prioritized over scale, **cautioning against rapid expansion without sufficient supports** in place. DSP staff emphasized that peer support models must actively protect workers from burnout, particularly when peers are supporting people with complex or ongoing needs.

Across audiences, **peer wellbeing** was repeatedly framed as **inseparable from participant safety and program sustainability**, with under-supported peers increasing risks of burnout, role drift, and harm.

System partners acknowledged that **under-resourcing peer roles undermines program credibility**, particularly when peer support is positioned as a lower-cost substitute rather than skilled work requiring investment.



### Research Highlight *Funding Sustainability*

Compensation often aligns with the **complexity** and **scope** of the peer role, as **paid roles typically support more individualized needs** (e.g., goal planning, navigation), and volunteers more often facilitate groups and/or provide connection and emotional support.



# Requirements for Peer Supporters Safeguards

## Training, Supervision, and Clear Roles Prevent Harm

Community-based mental health organizations emphasized that **training must be ongoing and layered**, not one-time, **combining core** peer training **with role-specific learning**.

Peer support organizations emphasized that **training and supervision must remain grounded in peer values**, cautioning against “over-clinicalization” that blurs the peer role.

Mental health system partners and DSP staff emphasized that **clear role definition, supervision, and escalation pathways are non-negotiable**, identifying role drift as a key risk to both peers and participants.

Some community mental health organizations and organizations that deliver peer support have online learning platforms to **deliver training and build a community of practice**.

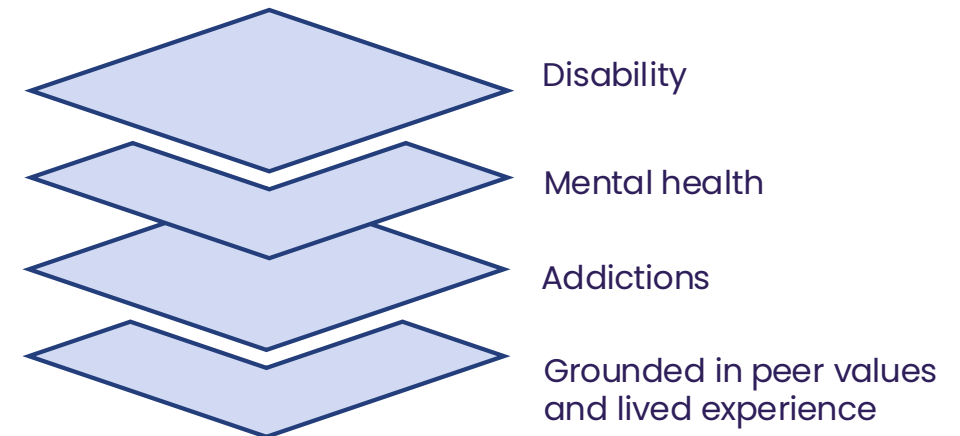


### Research Highlight

*Funding sustainability*

Training often includes (1) **initial guidance**, focused on role identity, ethics and boundaries, communication, trauma- and disability-informed practice, and escalation pathways, (2) **supervised** practice, with specific feedback delivered at the start of a supporter journey, and (3) **ongoing communities of practice**, with annual refreshers on targeted topics (e.g., crisis awareness)

## Skill-building for peer support workers to navigate intersectional challenges





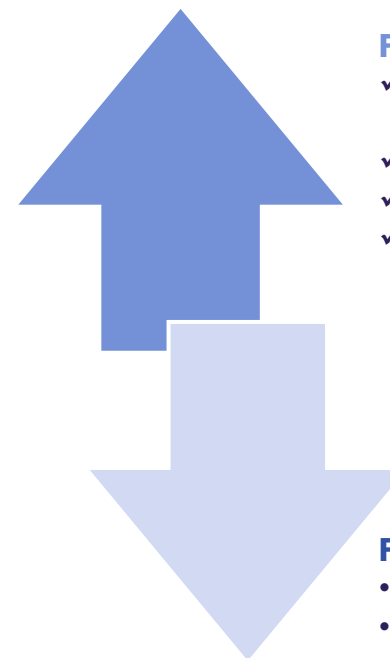
# Workforce Infrastructure and Program Sustainability

## Infrastructure and Oversight Enable Safe Delivery

Community-based organizations and system partners emphasized the **need for formal infrastructure**, including supervision, communities of practice, and governance mechanisms.

Mental health system partners cautioned that **poorly monitored or unsupported peer models increase risk**, even when intentions are positive.

DSP staff emphasized that **without infrastructure, peer supporters are left isolated**, increasing the likelihood of burnout and boundary challenges.



### Formal and Robust Structure:

- ✓ Consistent sources of support (e.g., training, supervision, communities of practice)
- ✓ Adequate compensation
- ✓ Sustained workforce safety
- ✓ Workforce stability and readiness

### Fragile and Unsustainable Structure:

- Unsupported emotional demands
- Under-resourced peer roles
- Inadequate compensation
- Precarious workforce

## Identified Service Gaps & Unmet Needs

*Infrastructure drives consistency*

Participants noted that while some peer services are funded or contracted, **training, certification, supervision**, and **workforce development** are not consistently overseen across the system. This creates gaps in **quality assurance, accountability**, and **integration** with broader mental health and disability services.



# Challenges to Continuity of Support

## Capacity, Geography, and Workload Shape Workforce Viability

Community-based mental health organizations emphasized that **managing supply and demand is a key design challenge**, balancing better matching with coordination and workload pressures.

Mental health system partners and DSP staff emphasized that **geography and regional inequities limit workforce availability**, particularly outside Central Zone.

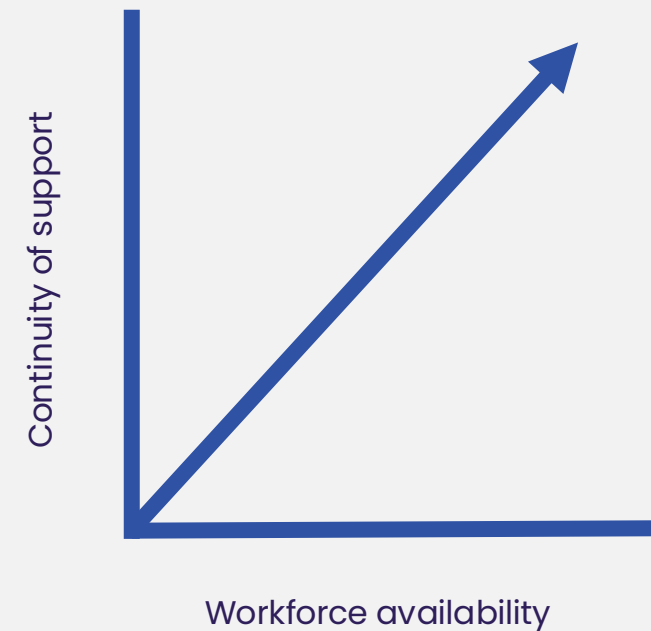
**Workforce shortages and uneven coverage** were consistently linked to disrupted continuity of support.



### Research Highlight *Geographic Realities*

Differences in population densities and available services between urban and rural areas indicate that program design and delivery may need to be adapted to fit distinct community requirements.

Increasing available workforce could improve continuity of support







# Equity, Accessibility & Safety

## **Sub-sections:**

- Accessibility Integration
- Geographical, Community-based Equity
- Safety Requirements
- Methods for Psychological Safety



# Accessibility Integration

## Accessibility must be built-in and not treated as a separate stream

Across audiences, **accessibility was pointed out as most effective when it's embedded across programs** – by embedding multiple ways to access and participate in existing supports, flexibility in format (in-person/virtual), and layered accommodations when needed.

Community-based organizations, mental health system partners, and service providers mentioned that the **current support landscape is built with standard pathways** (e.g., phone-first, rigid appointment structures, and inaccessible environments) **that do not align with the needs** of people with disabilities. Accessibility issues were identified at different stages from initial contact (e.g., communication challenges) to sustained involvement (e.g., transportation, proximity, flexible scheduling).

First voice also highlighted that phone- and video-enabled supports significantly reduce access barriers for people living far from available services. However, if not done well, this audience stated that in-person support is easier to understand than phone-based interactions – emphasizing the **need for a flexible range of options**.



## Key Takeaways

- Accessibility considerations should be reflected across the process of engaging with peer support (Access, ongoing participation, and continuity)
- Accessibility should be the default program design, with individualized accommodations layered on top

## Accessible & Flexible Program Design

Individualized **Accommodations**  
(Tailored supports as needed)

Choice & **Flexibility in Participation**  
(Movement between options over time)

Multiple **Ways to Access** Support  
(In-person, virtual, phone)

Accessible by **Design**  
(Core requirements embedded from the start)



# Geographical, Community-based Equity

## Addressing geography, transportation, and uneven regional availability

Equity concerns were strongly tied to where people live and whether they can physically (or digitally) access needed supports.

**Access to rural locations** and **accessible transportation** repeatedly appear as **structural barriers** that require program-level mitigation.

Across audiences, **equity** is framed less as an abstract value and more as a practical **design constraint**, emphasizing how the current landscape of services is operating in well establish zones such as large urban centers and how service access is dependent on transportation or internet access.

The need for **flexible service delivery** and **local customization** was stated in order to enable rural areas to receive these support programs. It was also noted that monitoring and evaluation practices should not disregard rural-based programming (for example, due to low attendance) when their impact remains significant.

### Audience Highlight

#### Community-based Organization

Community-based mental health organizations emphasized the impact of rural-based support services in people's lives.



### Identified Service Gaps & Unmet Needs

#### Geographical access barriers

**Where a person lives in the province can influence their access to support.** Engaged audiences from various regions emphasized the **geographic gaps** in service availability:

- x **Rural** and **smaller communities** often have far fewer (or no) services compared to larger urban areas
- x Services might technically exist but not everyone in Nova Scotia can physically access them
- x **Travel distances, lack of local providers, and poor transportation** leave many **rural residents** without support
- x Some support has moved to virtual delivery; however, **virtual services bring their own concerns** (e.g., effectiveness of virtual-only support), and not all areas have reliable internet access

! Creative and accessible solutions like virtual care need to be **flexible** to work in those settings.



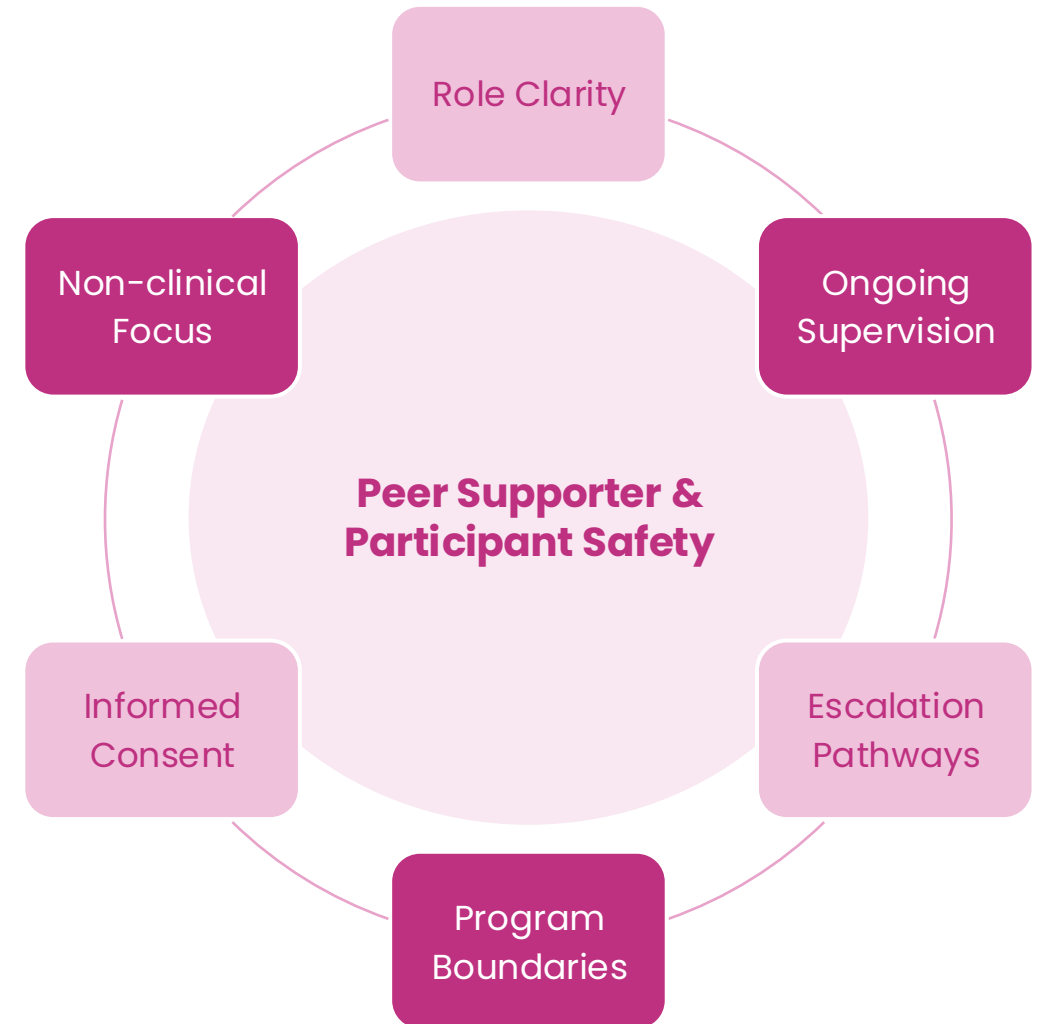
# Safety Requirements

**Safety requires clear scope, boundaries, training, supervision, and escalation pathways**

Safety was repeatedly framed as an outcome of **person-centered risk management** and **well-defined role integrity** – this includes preventing role drift into friendship and/or clinical-based therapy, ensuring ongoing supervision and reliable protocols in place, and building escalation pathways for out-of-scope needs.

Diverse audiences, including service providers and DSP staff, describe *good intentions* as an insufficient strategy to ensure safeguards are in place. Peer support can introduce harm if peers are **unsupported**, if participants peers can provide **clinical** intervention, or if the system **lacks clear coping planning pathways** (crisis, safeguarding, boundary violations). Supporting and protecting peer supporters has also been linked to participant safety and trust.

The need for clear and **explicit program boundaries** (including confidentiality, gifts/money, dual relationships) and a **solid non-clinical identity** for peer support initiatives was stated.





# Methods for Psychological Safety

## Psychological safety and trust depend on confidentiality, consent, and transparent information-sharing

Individuals' **willingness to participate** in initiatives such as peer support programs heavily **depend on trust safeguards**, including **confidentiality**, **explicit consent**, and **clear communication** regarding what information may be shared (with whom, and under what circumstances). This has been even more stressed when peer support is **integrated within clinical teams**. Concerns about **confidentiality in online and digital formats** was also highlighted, with enforced boundaries and non-negotiable requirements for safe peer support required to be in place.

**First voice** mentioned that **trust** is closely tied to the assurance that **personal information** will not be disclosed without permission – emphasizing how this concern extends beyond privacy aspects and into considerations for **emotional safety**, especially for those who have experienced stigma, or harm within current mental health systems.



### Audience Highlight

#### First Voice

First voice participants emphasized that feeling safe in peer support is **closely tied to trust**, with **confidentiality and explicit consent** identified as foundational to participation.

Strong expectations around **clear boundaries for information sharing** were raised, with participants noting that **assurance of confidentiality** enables **openness** and **meaningful engagement**.





# Peer Support Model Fit

**Sub-sections:**

- Peer Support Effectiveness
- Peer Support Model Flexibility
- Relational Connection & System Navigation
- Peer Support Considerations & Existing Infrastructure



# Peer Support Effectiveness

## Peer support is most effective when it is person-directed and aligned with individual goals

Across mental health system partners and First Voice participants, a consistent theme was that existing supports are often shaped by caregiver, program, or system priorities **rather than the individual's own goals, values, and readiness**. This misalignment can leave **important needs unmet**, particularly for people navigating long-term mental health challenges alongside disability.

Peer support was viewed as **well-suited to address this gap** because it can be directed by the person themselves and grounded in what matters most to them, including rebuilding relationships, finding purpose, and connecting with valued roles and community life.

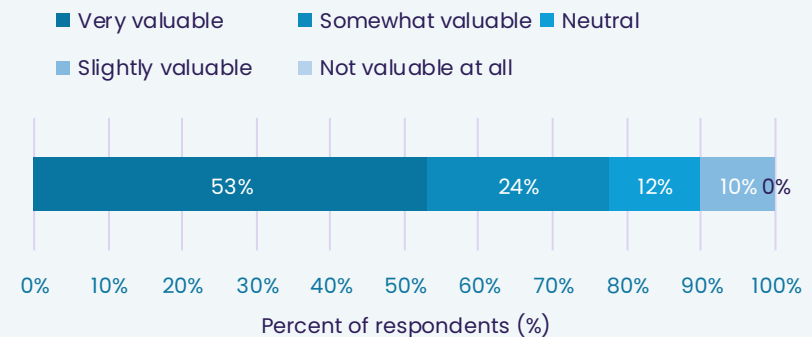
Participants emphasized that many individuals experience significant losses over time, such as housing, family relationships, or social connections, and that peer support can help address these **relational and identity-based needs** in ways that are not always prioritized within formal service models.



### Key Takeaways

- Peer support fits best when it is **guided by the individual's goals** rather than outside priorities.
- Person-directed support can address **relational and identity-based needs** often left unmet by traditional services.

## Q11: From your perspective, how valuable could peer support be for people with disabilities who experience mental health-related challenges?



Source: Service Provider Survey

Context: Over half of respondents view peer support as **very valuable (53%)**, followed by **somewhat (24%)** and **slightly (12%) valuable**. Fewer respondents viewed peer support as neutral or not valuable, suggesting **broad recognition of its relevance** and **potential role within the mental health support landscape for individuals with disability**.



# Peer Support Model Flexibility

## Flexibility in structure, format, and setting is central to model fit

Mental health system partners and DSP staff consistently noted that current mental health service models, often characterized by short sessions, rigid structures, and limited modalities, **do not adequately meet the needs** of neurodivergent individuals and people with disabilities.

Participants highlighted **gaps in availability of approaches** that support different communication styles, sensory needs, and preferences, including somatic, recreational, and relational forms of engagement, particularly for individuals with disabilities.

Peer support was seen as a **better fit** because it can be **delivered flexibility across multiple formats**, such as one-to-one connections, group settings, phone calls, shared activities, and support focused on building natural networks.

Participants also emphasized that institutional or hospital environments can be triggering for some individuals, and that peer support **delivered in neutral, welcoming, and community-based settings** better supports trust, comfort, and sustained engagement.



### Research Highlight

#### *Impacts of Flexibility in Peer Support*

Geographical differences, service distribution, and population diversity mean that no single peer support model will work everywhere. Evidence has shown that effective approaches often need flexibility in delivery (group, one-to-one, hybrid), format (virtual and in-person), and intensity to respond to different community contexts.



### Key Takeaways

- Rigid clinical structures **limit accessibility** for many people with disabilities and neurodivergent individuals.
- Peer support's **format and setting flexibility** is a core strength that supports engagement and accessibility.



# Relational Connection & System Navigation

## Peer support is valued for relational connection & practical navigation

Across community-based mental health organizations, DSP service providers, and First Voice participants, peer support was consistently valued for **reducing isolation, building trust**, and **helping people feel understood** through **shared lived experience**. Participants emphasized that these relational benefits are distinct from, and complementary to, clinical relationships, particularly for individuals who have long-standing experiences of not being believed, listened to, or adequately supported within formal systems.

In addition to emotional and relational support, peer support was also viewed as **valuable for practical navigation**, including understanding services, advocacy, and bridging the disability and mental health systems.

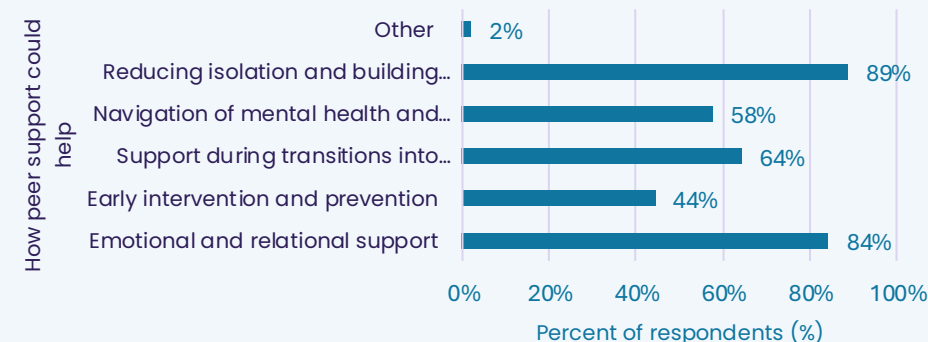
This combination of relational connection and practical assistance was seen as a defining feature of peer support within the broader mental health support landscape.



### Key Takeaways

- Shared lived experience helps **reduce isolation and build trust** in ways clinical relationships may not.
- Peer support is valued for both **emotional connection** and **practical system navigation**.

## Q12: In what ways could peer support be particularly helpful?



Source: Service Provider Survey

Context: Respondents most frequently valued peer support for **reducing isolation and building connection (89%)** and providing **emotional and relational support (84%)**, with additional value placed on **transition support (64%)** and **system navigation (58%)**.



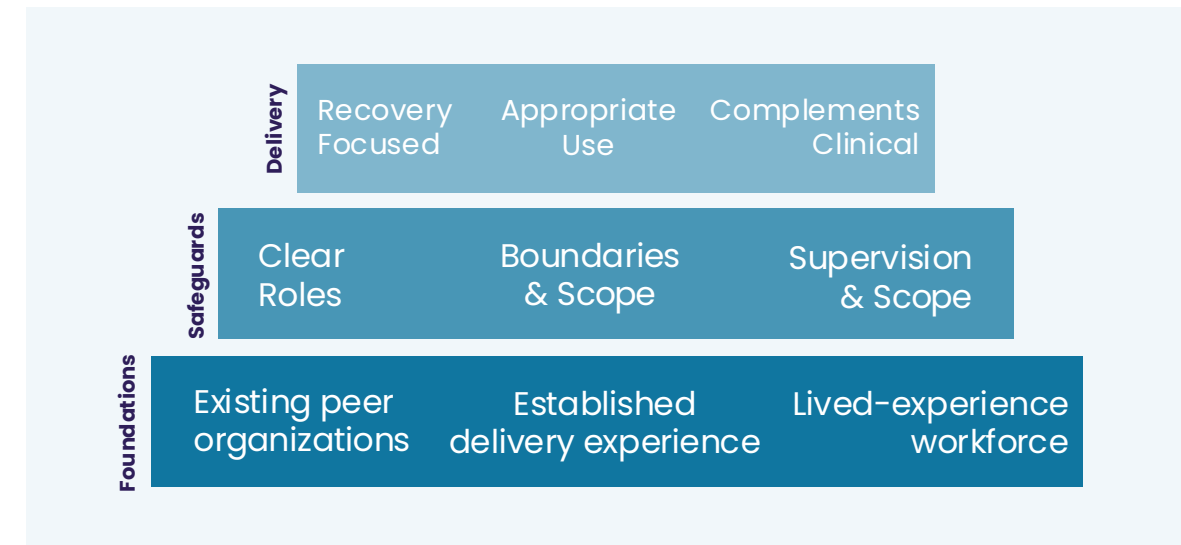
# Peer Support Considerations & Existing Infrastructure

**Clear role definition, boundaries, recovery-focused scope, & existing peer infrastructure are essential for safe & effective peer support**

Across engagements, system partners and peer support organizations emphasized that peer support must be **clearly differentiated from clinical roles**, with lived experience as its core qualification. Participants cautioned that **blurring peer and clinical responsibilities can create role confusion** and undermine the distinct value of peer support. Clear boundaries, conflict-of-interest safeguards, and defined escalation pathways were consistently identified as essential to ensure safety and appropriate use of peer roles, particularly given that peer support is **not appropriate in all situations**.

Within this context, participants highlighted **strong community readiness and existing peer infrastructure** as key strengths. Community organizations noted that people with physical, intellectual, developmental, and neurodivergent disabilities already access peer support in significant numbers, and that long-standing delivery experience has generated practical knowledge about

**effective approaches, risks, and boundary management.** Strengthening and resourcing existing peer support capacity was viewed as a way to support clearer role definition, reinforce a **recovery-focused scope**, and strengthen overall system fit.



## Key Takeaways

- **Clear boundaries, role clarity, and escalation pathways** are essential for safe and effective peer support.
- Existing community-based infrastructure provides a **strong foundation for recovery-focused** peer support delivery.



