Working as a peer specialist in FACT: how do they make sense of their role?

A qualitative study in Norway

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“*Sure, you can become drug-free - but first you have to survive*”

(Nasjonal overdosestrategi 2019-2022)

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Bakgrunn: Det er en økende trend i Norge hvor personer med erfaring fra rus og psykiatri blir ansatt i helseforetak som brukerspesialister for å bidra i terapeutisk behandling i tverrfaglige team. Det ønskes forståelse for hvordan rollen til en brukerspesialist oppleves i møte med pasienter og som arbeidstaker i helsevesenet. Forskningsspørsmålet er: *Brukerspesialister i FACT, hvordan opplever de rollen sin?*

Metode: Det ble gjennomført et kvalitativt semistrukturert dybdeintervju ble gjennomført med syv brukerspesialister, begge kjønn. Det ble foretatt et utvalg fra FACT – team i Norge. Intervjuene ble tatt opp med lyd, transkribert ordrett og tematisk analysert.

Resultater: Fire temaer ble utarbeidet for å utforske forskningsspørsmålet. Dette var: 1) Hvordan forstår brukerspesialister sin rolle i forhold til pasientene de jobber med under behandling og restitusjon? 2) Hvordan opplever brukerspesialistene sin posisjon i et tverrfaglig team? 3) Hvordan håndterer brukerspesialistene dilemmaene og konfliktene ved å være brukerspesialist, for eksempel i forhold til selvutlevering og håndtering av egne følelser? 4) Hvordan håndterer brukerspesialistene sine grenser for selvutlevering i forhold til pasientene. Det er en enighet blant informantene at det er en utfordring å ikke bli påvirket av de andre profesjonene på teamet, og dermed tre over i rollen som terapeut istedenfor å være en likemann. Det er også en enighet blant informantene om at de er tatt godt imot i teamene de jobber og de at de blir hørt og respektert. Det er derimot en uenighet om grenser for selvutlevering. Noen har ingenting imot det og utleverer ukritisk, og andre er mer selektive med hva de deler med både pasienter og med medarbeidere. Det er også uenighet om det er behov for veiledning for å håndtere sine egne følelser i jobben de har.

Konklusjon: Hensikten med brukerspesialist er å få en likemann til pasienten inn i behandlingen i rus- og psykiatri tjenesten. Tidligere studier viser til gode resultater for pasienter. Det kan derimot være en fordel for brukerspesialisten å ta utdanningen "medarbeider med brukerefaring" som et stikk for å forstå rollen sin bedre. Brukerspesialisten bør ha en godt utarbeidet arbeidsinstruks på stedet. Studien viser til et behov for veiledning, der brukerspesialisten hjelp får til å håndtere følelsene sine. Studien reiser spørsmål om brukerspesialistenes tilgang til veiledning, spesielt i forhold til å håndtere selvutlevering. Bruk av brukerspesialister reiser dermed en rekke problemstillinger som krever videre diskusjon.

Nøkkelord: Brukerspesialist i arbeid, peer specialist, rusbehandling, substance abuse treatment.

Abstract

Background: There is a growing trend in Norway where people with experience from substance abuse and psychiatry are employed by health trusts as peer specialists to contribute to therapeutic treatment in interdisciplinary teams. An understanding is needed for how the peer specialists perceive their role in meetings with patients and as an employee in the health service. The research question is: *Working as a peer specialist in FACT: how do they make sense of their role?*

Method: A qualitative approach using semi-structured interviews was conducted with seven peer specialists, both genders. Recruitment was through the FACT – team in Norway. The interviews were audio recorded, transcribed verbatim and thematically analysed.

Findings: Four themes were developed to explore the research question. These were: 1) How do peer specialists make sense of their role in relation to the people they work with during treatment and recovery? 2) How do peer specialists experience their position in an interdisciplinary team? 3) How do the peer specialist manage the dilemmas and conflicts of being a peer specialist, for example, in relation to self-disclosure and the management of their own emotions? 4) How do the peers handle their limits of self-disclosure in relation to the patients. There is a consensus among the informants that it is a challenge not to be influenced by the other professions on the team, and thus step into the role of therapist instead of being a peer specialist. There is also an agreement among the informants that they were well received in the teams they work in and that they felt heard and respected. However, there were differences of view about the limits on self-disclosure. Some have nothing against it and use it in their work, and others are more selective about what they share, to both patients and colleagues. There was also disagreement about whether guidance is needed to manage their own feelings in the job they have.

Conclusion: The purpose of the peer specialist is to provide someone who has experience to the patient with regard to treatment in the substance abuse and psychiatry service. Previous studies have shown good results for the patient. On the other hand, it can be an advantage for the peer specialist to take the education "employee with user experience" as a way of being prepared for and understand their role better. The study raises issue about peer specialists' access to guidance, especially in relation to managing self-disclosure. The use of peer specialists thus raises a number of issues that require further discussion.

Keywords: Brukerspesialist i arbeid, peer specialist, rusbehandling, substance abuse treatment.

Chapter 1 Introduction

1.1 Background and rationale to the project

Drug abuse is one of the leading causes of death among young people in the world. More than 200,000 people die every year globally from drug abuse, according to the UN (Helsedirektoratet, 2020). Despite one of the world's best health and welfare systems, Norway is at the top of the statistics on registered overdose deaths in Europe and has done so for many years. The parliament has stated that we cannot accept that so many people die from overdose (Nasjonal overdosestrategi 2019-2022).

This thesis focuses on the peer specialists' work and role in drug treatment and prevention in the health care system in Norway. While several studies have examined the mechanisms that are set in motion between the peer specialist and the patient, the peer's work as a member of a multidisciplinary team in the health system has rarely been examined and is the focus of this thesis. It has been argued that one strategy for increasing the effectiveness of rehabilitation and treatment is the introduction of a peer specialist role into the drug treatment and recovery team, that is to say, someone who has personal experience of drug abuse and / or treatment in the health care system.

People employed in the national health service in Norway with experience of drug abuse are named with several different titles, for example peer, experience consultant, consultant in user participation, user specialist, employee with user experience, professional consultant with user experience and paid peers (Weber & Jensen, 2016). This thesis uses the term peer specialist.

1.2 Drug use in Norway as a public health issue

According to the World Health Organization (WHO, 1946) health is more than the absence of disease. It has positive aspects such as coping, well-being and quality of life (WHO, 1986). Public health focuses on how health is distributed in the population, which groups have better or poorer health and focuses on prevention and promotion rather than only treatment. However, recovery from, for example, drug abuse, is an important part of public health and health promotion, especially because it relates to prevention of future drug problems and aims to improve quality of life. The Public Health Act of Norway (Regjeringen, 2012) defines public health work as society's efforts to influence factors that directly or indirectly promote the population's health and well-being, and prevent mental and somatic illness, injury and disorder. It protects threats against health, and the distribution of factors that affect health. Some of the main features of public health work are that it is a job for the society, it is group- and population-oriented and it is promoted through factors that have positive or negative effects on the population's health. Public health is based on a population perspective (Nasjonalforeningen, 2019). In this thesis, the relevant part of society's efforts relates to the part of the healthcare system that supports the population of drug users towards recovery.

Behaviour change, both as an idea and a goal, has a rich history in public health. Behaviour, such as using drugs and becoming addicted to them, is an important factor for everyone's health. Worldwide, smoking, alcohol and drug consumption account for a significant proportion of premature death and disability. Understanding how people develop certain behavioural patterns is therefore central in public health work (Thurston, 2014, p. 12).

Lower consumption of drugs in the population can provide a significant public health benefit and help to reduce social inequality in health (Rossow, 2018). The publication *The Gradient Challenge* from the Norwegian Directorate of Health and Social Affairs defines social inequality as differences in health throughout the social hierarchy. Furthermore, it also includes the health problems of particularly vulnerable groups, and geographical differences in health (Folkehelseinstituttet, 2007). Health behaviours such as smoking, physical activity and diet are greatly affected by economic and social factors. At the same time, we know that health behaviour is of great significance for a number of non-communicable diseases. Low socioeconomic status increases the likelihood of an unhealthy diet, little physical activity and smoking. When it comes to alcohol use, slightly different mechanisms come into play. A central assumption has been that alcohol consumption increases with higher socio-economic status. We see, for example, differences in drinking patterns and in preferences of alcohol that does not follow simple patterns, neither over time nor geographically. It has been common to assume that the negative consequences of alcohol have been less among those with high socioeconomic status, despite a higher consumption. Conditions such as drinking patterns, work affiliation, social networks and resources can play a role in terms of consequences and coping.

The Norwegian Directorate of Health also defines social inequalities in health as systematic differences in health status, which includes social and economic categories, especially occupation, education, and income. They also say that health differences are socially created and possible to do something about (Helsedirektoratet, 2018).

The use of alcohol and other drugs has both immediate and long-term effects on health and quality of life. The risk of accidental and violent injuries increases in connection with drug abuse. High consumption over time also increases the risk of certain cancers, cardiovascular

disease, mental disorders, liver damage, suicide, and suicide attempts. Risky use of alcohol and drugs also increases the risk of social problems. Examples of this are loss of work and income, broken relationships with family and friends and exclusion from social arenas. Risky use can also contribute to reduced health and quality of life for the users' spouses and children, work colleagues, friends, and neighbourhoods. Society's costs associated with drug use are therefore high. There are large production losses in working life and costs for health and social services, the police, and the judiciary (Rossow, 2018). Illegal drug use also contributes to the spread of infectious diseases, including HIV / AIDS, hepatitis B and C, and tuberculosis (Sindelar & Fiellin, 2001). Therefore, effective drug prevention work provides a great societal benefit, both in terms of public health and the use of society's resources (Rossow, 2018). Nonetheless, drug use is common among some groups in some countries making effective recovery-oriented drug treatment that prevents relapse of particular importance.

The ambitions of the Public Health Act are that drug prevention is seen as an integrated consideration in public health work (Helsedirektoratet, 2018). Drug abuse is one of the most important risk factors for non-communicable diseases and can affect mental health. Mental health is an equal part of public health work, is an important area for the Ministry's public health work and is a follow-up to the Public Health Report (2018-2019) "Good lives in a safe society". Public health work must therefore contribute to mental health promotion measures for the entire population. Risk factors must be reduced, and health-promoting and preventive measures must be strengthened (Regjeringen, 2020).

The low effectiveness of preventive measures leaves drug treatment as one of the most important ways to combat the illegal use of drugs. Drug treatment can reduce use and crime and increase the function of individuals (Sindelar & Fiellin, 2001). At the same time, only a

fraction of those who need treatment receive it. Sjåfjell (2020) refers to an estimate which indicates that only 7% of those with alcohol problems receive treatment (Sjåfjell, 2020).

A recent innovation in drug treatment to reduce barriers and increase the effectiveness of treatment is to employ people who have been users themselves and / or have been in treatment (Weber & Jensen, 2016). These peer specialists have been used in many countries, including in Norway.

1.3 The purpose of this master thesis

The practice with peers was introduced to me through knowledge of the FACT model which began in Norway in 2010 and is now being developed throughout the country. FACT (Flexible Assertive Community Treatment) is an interdisciplinary team that provides long-term follow-up to people with severe mental disorders in their community. The model is aimed at people who, in addition to their serious mental illness, often have limited social functioning, unstable living situations, problems finding work, financial difficulties and other factors that lead to a low quality of life such as drug use (Van Veldhuizen, 2013). An essential element of FACT is the hope that the peer represents to the person entering the recovery process. The peer is living proof that improvement is possible. In addition, they use their own experiences with drug abuse and experiences with the help system to support the improvement of other patients, as the peer is one of several equal members of the treatment team (Van Veldhuizen, 2013). Nevertheless, the role and function of the peer is only vaguely described and defined. This means that a peer specialist has wide scope for interpretation of their role. How they have interpreted this vagueness is the backdrop to this study.

Therefore, the purpose of this study is to explore the peer specialist's role in an everyday work perspective in order to understand what sense they make of their role, especially in relation to other team members.

1.4 Research questions

The research question is:

Working as a peer specialist in FACT: how do they make sense of their role? A qualitative study in Norway.

To shed light on the problem, the following study questions have been formulated:

- How do peer specialists make sense of their role in relation to the people they work with during treatment and recovery?
- How do the peer specialists experience their position in an interdisciplinary team?
- How do the peer specialists manage the dilemmas and conflicts of being a peer specialist, for example, in relation to self-disclosure and the management of their own emotions?
- How do the peers handle their limits for self-disclosure in relation to the patients?

Chapter 2 Literature review

2.1 Introduction

The aim of this chapter is to establish what is already known about the topic in a way that it can act as a background to this thesis and at the same time illustrate where the gap is that the thesis focuses on (Bryman, 2016). The purpose is to present and discuss literature that is relevant to the study's research question, and later illuminate the empirical evidence in a scientific way in the discussion chapter.

2.2 Peer Specialists in drug and mental health rehabilitation services

Peer specialists are well integrated into several drug treatment models as in Flexible Assertive Community Treatment (FACT) (Bassuk et al., 2015). This thesis focuses on peer specialists in an interdisciplinary team, like FACT. FACT is an interaction model between the specialist health service and the municipality, and targets people with serious mental disorders, substance abuse and with large and complex problems. FACT was developed in the Netherlands in 2003. The Norwegian health authorities have since 2009 stimulated the trial and implementation of the interaction model. The first FACT team in Norway was established in 2013, and today there are approximately 60 FACT teams across the country, including pre-projects. There is little knowledge of the usefulness and efficacy of the FACT model both nationally and internationally (Van Veldhuizen, 2013).

Inspired by the thinking of USA's ACT teams, the Netherland started with "Assertive Community Treatment" abbreviated to ACT. These teams were further developed into FACT (Flexible ACT). FACT offers patients continuity of treatment, help, and follow-up. While ACT focuses on 20 % of the people who have the most serious disorders, FACT includes a wider spectrum of disorders. Moreover, FACT drives outreach work based on an integrated

and wide interdisciplinary team. The team consists of a nurse, psychiatrist, psychologist, peer specialist, social worker, substance abuse specialist and work specialist. This provides more opportunities for improvement and treatment. The FACT teams usually recruit patients from a small area and get opportunities to cooperate with various agencies in the local community. The Netherlands have, today, 150 fact teams and believe that the number would increase to 400 to 500 in years to come. This success has attracted international attention. Teams have been started in London and in several cities in Belgium. Interest has been shown in the US, France, Sweden, and Norway (Landheim & Odden, 2020).

In recent years interest in the hiring of peer specialists has increased in the mental health and substance abuse field (Weber & Jensen, 2016). Substance abuse and mental disorders affect each other mutually and require special attention. People with concomitant substance abuse and mental illness often use drugs in a devastating way and they easily fall outside treatment measures. Some people have difficulty to be independent in society, some have marginal economies and belong to the poorest, and many have poor quality of life. Although there has been increased attention on this patient group in recent years, there is still much missing when it comes to investigation, treatment, and follow-up. Some remain undetected because we have not seen the mental illness behind the drug problems or substance abuse behind the mental illness. If we know which people are most likely to develop ROP (rus og psyikiske lidelser – drug and mental health) disorders, they can be better identified and treated. Summaries from population surveys in Europe and the United States, as well as other research, shows that the more severe the substance abuse disorder, the higher is the incidence of mental disorders, and the more severe the mental disorder, the higher is the incidence of substance abuse disorders. People with substance disorder have a higher incidence of mental disorders than people with alcohol disorder (Helsedirektoratet, 2011).

The experience that peer specialists sit on is potentially an important resource and expertise that can be used to have good effect within the context of service provision in both substance abuse and mental disorder. It is important to be aware of the peer specialists' roles and mandate, so that it is clear where and how to involve them (Weber & Jensen, 2016). Even though hiring peer specialists in substance abuse and mental health services in Norway is a national priority (St. Meld 11, 2015-2016), there is no national standard for training, certification, or regulation of peer specialists. Different day-courses have been developed to prepare employers and other skilled workers in the services, but these have not been established on a permanent basis and few services have used them (Åkerblom et al., 2020). Mental Health America is America's leading community-based non-profit organization dedicated to addressing the needs of those living with mental illness and to promoting the overall mental health of all. They also have a certification program to become a certified peer specialist. It is an examination-based, legally defensible certification. To be approved for the examination, applicants must meet a list of requirements (Mental Health America, 2021). The Texas Institute for Excellence in Mental Health also have a peer specialist training and certification program, that was updated in 2014. The certified peer specialist workforce is relatively new in the behavioural health and substance abuse field, with certification programs first emerging in 2001. Within this short timeframe, states have recognized the potential of peer specialists to improve outcomes by promoting recovery. As of March 2014, 38 counties in the District of Columbia have established programs to train and certify peer specialists and eight counties are in the process of developing and/or implementing a program (Kaufman et al., 2014).

Many peers in mental health care experience high conflicting expectations, and that they themselves must find out what the position should interpreted (Fleiner, 2016). It is important

that good preparations are made in the working environment before hiring peer specialists. There should be neat and clear job descriptions, so that one knows what the employee is going to do and can be expected to do. There was in 2016 around 150-160 peers in Norway in mental health and substance abuse services, in the municipalities and in the specialist health service. Many have found the role demanding, because the expectations are so colossal for these positions both from the employers, from the user environments and from colleagues in the academic community. Many of the expectations have also been internally contradictory (Fleiner, 2016).

Peer specialists bring users' experiences into treatment. It is generally assumed that healthcare professionals are experts in their own fields. However, the case is not so straightforward regarding peer specialists who enter employment with no formal qualifications since it is their life experience and life skills that are viewed as important. This may make it more difficult to achieve equality of status and equality of knowledge between members of an interdisciplinary team in which a peer specialist is located. Weber and Jensen (2016) further state that a peer employment need to be well integrated by the management, and it must be clear what the purpose of the position is to the peer specialist as well as other members of their team. The purpose must be stated in the announcement text and job description. They also emphasize the importance of providing support and guidance to the peer specialists. This is to provide the opportunity for reflection and development of tasks and the role. At the same time Franke et al. (2010) have concerns that the more the peer specialist is professionalised, the more it can resemble the structure of established mental health services, and this can dilute its emancipatory value. Resnick et al. (2004) have argued that peer specialists employed within a mental health service may be influenced by professional attitudes, thereby detracting from their ability to act as peers. The peer specialists who operate within the environment of

clinical and professional support services can face considerable discrimination from professional staff and exposure to stress. Weber and Jensen (2016) argue that people with previous experiences with drug addiction and/or mental health problems have experienced being met with scepticism and prejudice, to the extent that they do not function well in work. Mowbray et al. (1998) also noted that a lack of support from supervisors was an added barrier. A lack of role models – there is often only one peer specialist within an interdisciplinary team in many countries such as Norway (Landheim and Odden, 2020) – and tension or confusion over issues of confidentiality, boundaries and friendship may be further impediments to peer support. Mulvale et al. (2019), in an exploratory case study from Canada and Norway, concluded that transformation efforts need to be effective, and leaders must prioritize peer support and back this up with action. Leaders must actively inspire a vision for the integration of peer support workers as part of the person-centred care team, while recognizing that adoption of peer support requires a culture change that takes time (Mulvale et al., 2019). These issues have not been well explored in the Norwegian system of drug addiction services and is one of the gaps that this study will examine.

2.3 Organizational perspectives on delivery services including peer specialists

Ibrahim et al. (2019) wrote a systematic review on the implementation of peer specialists in the treatment of adults with mental challenges. The goal was to find out whether the use of peer specialists facilitated, or was a barrier, in the treatment of patients with mental illnesses. Publications were included if they reported on the implementation of the peer specialist role in the treatment of adults with mental illnesses. Data was analysed with the use of narrative synthesis. It included six international studies. Ibrahim et al. (2019) concluded that the role of a peer specialist was facilitated if there were clear goals, and that they had a central position in the service network. At the same time, if the role is clearly defined, it is a code for

execution with appropriate limits, and adjustments to maintain a high role status. Franke et al. (2010) concluded that some peer workers felt instantly welcomed while others experienced strong barriers to being accepted as part of the team they were hired in. Some peer specialists had to work hard to change the attitudes of other staff, which had implications for the wellbeing of the peer specialist. Ibrahim et al. (2019) also concluded with some barriers. Treatment protocols were sometimes inflexible and limited person-centred principles, which were particularly relevant to how the peer specialist is supposed to work. The existing traditional workplace hierarchies could give rise to peer specialists perceiving themselves as stigmatised and feeling like outsiders. Mulvale et al. (2019) say that it may be important to offer full time jobs for peers for better integration, and also for them to have extended health benefits to support their own health. Ibrahim et al. (2019) says further that there were challenges with supervision and peer specialists can have a sense of incompetence and lack of confidence. There was also an uncertainty about the level and limits of self-disclosure, which can create a mismatch between the expectations of the employer and peer specialist. Peer specialists often can experience a stressful working environment that creates mental unrest, which goes beyond the actual work that the peer specialist will perform for patients (Ibrahim et al., 2019).

Ehrlich et al. (2017) analysed the answer to the research question: “How were peer support workers integrated into care delivery processes?” in a region of Australia. Participants in this study were recruited from a recently implemented sub-acute mental health care team in South East Queensland, aiming to provide intensive case-management for people with mental illness. At the same time clinicians enthusiastically embraced the idea of including peer support workers in care teams, but they did not fully understand the role of the peer support worker, or how to engage them in clinical care. Ehrlich et al. (2017) also says that beyond

their lived experience of mental illness, a common ground from which peer support workers could develop their role was lacking.

Holst and Mohn-Haugen (2021) say that the peer specialist survey (a quantitative study) has been conducted in Norway annually since 2015 and provides an overview of the work situation of peer specialists, how they feel and how the role develops. It was a mixed survey, with a semi-structured questionnaire. The survey was sent out to The Experience Centre's members, that is all peer specialists, in the early half of 2020 and was made in cooperation between The Experience Centre and the Trade Union. The Experience Centre was founded in 2017, and the organization has around 150 members. The centre of experience is the national interest organisation for peer specialists. The centre works to create meeting places for the occupational group, to promote knowledge of peer specialists and work to strengthen the peers as a professional role. The survey was sent out to 118 peer specialists by e-mail and 72 responses were received, a response rate of 62 %. The survey was carried out anonymously. The survey clearly showed that peer specialists lack guidance, especially from others with experienced backgrounds. Just 10% of respondents reported that they did get guidance from others with experienced backgrounds, while 45.8% said they did not get guidance at all. Based on the survey, a pilot project was started with guidance from and for peer specialists. The pilot continues to work on a plan for guidance for the peer specialists who want it. This shows that the survey can give an indication of what needs to be focused on and prioritised going forward if the situation is to improve. In free text fields about what training and support the peer specialist feel they are missing today, they received 51 responses. Here, guidance, especially from other peer specialists, was in demand. Several wrote that they missed individual guidance and guidance in general. Others point out the need for professional replenishment and closer follow-up from the employer. Still others want an increased focus

on self-care, ethics, journal systems and a focus on relatives. Four of the respondents stated that they were satisfied with the offer they received (Holst & Mohn-Haugen, 2021). Franke et al. (2010), an Australian study about implementing peer support in health undertakings, say that those professionals who were best prepared to take on peer specialists had the least problem establishing the role of the peers.

It is clear from both international and Norwegian research that the integration of peer specialists can be positive for patients, although it has been found that the integration of peer specialists also has dilemmas and challenges. Studies suggest that peer specialists have a major impact on patients in relation to recovery variables in both the healthcare field and drug addiction field, such as quality of life, hope, and empowerment (Davidson et al., 2012; Borg et al., 2017). Reduction in relapses and symptoms also proves highly effective in drug treatment with peer specialists (Bellamy et al., 2017). Davidson et al. (2012) also say that integrating peer specialists, and adopting experience skills, involves changes in both culture and practice in the services, and there are several challenges related to that. Attempts to create change often meet some resistance, such that tensions and dilemmas may arise when introducing experience and hiring peer specialists. Kilpatrick et al. (2017) say professional groups do not always recognize experience skills and that experience knowledge can be difficult to put into words.

Previous Norwegian and international research has shed light on how peer specialists contribute to mental health treatment (Borg et al., 2017), but little about how peer specialists contribute to substance abuse treatment and if they contribute to changing the services. While the benefits for patients seem to be well established, there has been little research on how peer

specialists experience being integrated into the service, which is one of the gaps that this research project aims to address. How peer specialists perceive their role within an interdisciplinary team will also be explored. Another discrepancy in the study is that there are few studies in Norway about the peer specialist's role in drug work. The research for this thesis aims to give a voice to peer specialists in order to better understand these experiences.

2.4 Employees with user experience – the education

Hordaland (a county in Norway) has its own school for people who want to become an employee with user experience in the field of mental health, MB (Medarbeider med brukererfaring). The programme is a collaborative project between NAV, Bergen Municipality and Helse-Bergen. Those who apply for the course, and there are more applicants than places, must have a clarified relationship with their own past, and they must have used the support system in their own recovery process. It is a course for those who want to use their own coping strategies in working in the field of mental health. The aim of the programme is to get people into the labour market or into activity, as well as to add new expertise in mental health care. During the 10 years the programme has been in Bergen, there has been a positive change in attitude, from scepticism to curiosity and a warmer welcome to make room for students in the Health Care System (Trane, 2020).

There are different attitudes today than there were before, and there is a change in society, a change that is happening gradually. The programme focuses both on the role of helper and on the differences between being personal and private and aims to qualify the participants for the interdisciplinary work needed in mental health care. There is a focus on up-to-date knowledge of the field, and supervision is a key part of the course. Other important topics throughout the education are attitudes, recovery, empowerment, communication, conversational techniques,

stress management, and using the lived experiences. People with self-experience working in mental health care have an important role in creating hope in users they meet, and in many cases, they are important role models. The programme focuses on how they can be good role models that give hope to users, next of kin and to other professionals. The lived experience is therefore central. The programme focuses on recovery and coping strategies that the participants themselves used in their recovery process (Trane, 2020).

Today, there is no requirement for education to get a job as a peer specialist, but it is an advantage to have prior knowledge and importance with good interpersonal skills, as well as a reflective relationship to one's own history (Erfaringssentrum, 2021).

2.5 Theoretical framework

This is an exploratory qualitative study in which the review of the literature stands as the background to the empirical work (Bryman, 2016). This means that a primarily inductive approach to the empirical data will be used in the analysis. However, in reviewing the literature it is evident that some constructs may be relevant to the analysis. For example, Paulo Freire's theory of liberation and the concept of empowerment may be relevant to understanding how peer specialists perceive their work (Freire, 2011). Emancipation pedagogy is an educational direction and movement that has played an important role in thinking and practice, both around aid work and educational work in general. Dialogue pedagogy and assistance built on popular participation are only among some of the directions that originate from liberation educational ideas (Ingebrigtsen, 1994).

Freire's basic thesis is that man’s central goal is to seek a richer human dignity (Freire, 2011, p. 24). He shows how ignorant, passive, and oppressed people can develop self-esteem and

become critical and active. This happens through meetings with others – teachers as well as political leaders, a meeting based on dialogue (Freire, 2011).

The term "empowerment" is central to health promotion work (Mæland, 2005). It can best be translated in relation to winning greater relative power and control over one's situation. Burke et al. (2018) argue that evidence suggests that empowerment, self-efficacy, and internalized stigma are theoretically linked and implicated in the change processes involved in peer support (Burke et al., 2018). Schutt and Rogers (2009) also concluded that a peer specialist process was a key to successful empowerment (Schutt & Rogers, 2009).

Empowerment is a concept used in social work that is closely related to the user experience principle. Personal empowerment is defined in a society to be how individuals and groups that are in powerless positions or situations should be strengthened and gain increased self-esteem, as well as knowledge and skills. The definition of empowerment is often aimed at an individual focus, such as self-esteem. The term can be divided into two dimensions, however, one that is about the individual and one that is about the structural, or to put another way, the circumstances that individuals live and work in. Above, the personal dimension is explained. The structural dimension addresses the power relations, barriers and social structures that help maintain injustice, inequality and the inability to have control over one's own life. The central aspect of empowerment is to see the connection between the problems they have on the one hand in the individual's life situation and the problems on the other hand through the structural conditions. In other words, it is about seeing a connection between the structural and personal plan. Peer specialists have many opportunities to develop increased empowerment, both through mastery at work, but also through their own recovery process.

One can see that empowerment is largely used in connection with various groupings that are in a power-based position, including children, adolescents, disabled people, immigrants and substance abusers. It is also highlighted that empowerment is used by those who are users of the services and have the right to control their services and health services (Sivecevic, 2019, p. 22). However, in this thesis, the concept of empowerment is also relevant to understanding how peer specialists experience everyday working life as part of a multidisciplinary team.

Chapter 3 Methodology

This chapter describes the research process used in this study. A qualitative approach was used in this thesis. The empirical direction was based on a qualitative paradigm, set out to understand the experiences and perceptions of peer specialists in their everyday lives. The aim was therefore to try to understand working as a peer specialist from the point of view of those with experience of working as a peer specialist, allowing them to give voice to their perceptions and experiences. Thus for example, the research aimed to understand how a peer specialist feels in the workplace, do they feel stigmatised and how and why do they experience challenges in finding their place as a respected equal in an interdisciplinary team?

A qualitative approach is well suited for studies on topics where there is little research before, as is the case in this study, because the topics can be exploratory. It is an approach where there are particularly high demands on transparency and flexibility. Studies of new cultural phenomena are a good example of this. Qualitative research is informed by the field of phenomenology, in that it has a commitment to understanding phenomena based on the

perspectives of the people we study, who in this task are peer specialists, and to describe the experiences they have. The phenomenon is based on an underlying assumption that social reality is the way people perceive it, for example in relation to a person's work situation and the position in the work team. A strength of qualitative approaches is that we can study phenomena that are difficult to access by other methods (Thagaard, 2018). In contrast to phenomenology, the hermeneutic approach does not build all understanding on the understanding where the researcher's prior knowledge is emphasised on the subject to be explored (Kvale & Brinkmann, 2009). This study has a descriptive exploratory and interpretive design. That is, a phenomenal-hermeneutic approach, as I am looking for peer specialists' understanding and interpretations of the topic, as well as linking the interpretations of the peer specialists' statements to a theoretical understanding. Peer specialist is a relatively new profession, and little has been researched on the role.

3.1 Semi-structured depth interview

Semi-structured interviews were used as the data collection method. There has been prepared a semi-structured interview guide as data collection method (Appendix 1). The semi-structured interview is considered to provide some structure to the interview as well as providing enough room for informants to respond freely about their employment as peer specialists. This means that they can speak openly about things that are important to them without being limited. At the same time, the topic of the interview and the specific open questions asked steer the informants into directions that are of interest to the study. Kvale and Brinkmann (2009) point out that this is a good way to gain a deeper understanding and insight into how the interviewee reflects on their own thoughts and experiences. A semi-structured format, is therefore, attractive, and open for the reflection that the study intends to explore. In contrast to structured and unstructured interviews, semi structured in-depth interviews are

characterized by a partial structure where the interview guide is based on topics related to relevant theory and/or research question and previous research (Thagaard, 2018).

The interview guide used in this thesis contains four main areas that relate to the objectives of the study and a total 15 questions. These objectives relate to becoming a peer specialist, the reality of working as a peer specialist with patients, the reality of working as a peer specialist in an interdisciplinary team and their own reflections on their own journey as a peer specialist. On each objective, formulated questions were prepared that contained both open and some closed questions. To validate the interview guide, it was discussed and reviewed with the supervisor. The discussion led to some changes that improved the data collection process (Christensen, Nielsen and Schmidt, 2011).

3.2 Choice of informants

The interviewees for the study were peer specialists recruited through FACT. They had the knowledge and experience with their own employment as a peer specialist in an interdisciplinary team. They were therefore viewed as key informants. The choice of peer specialists was made strategically to best illuminate the issue (Malterud, 2011). This means that the peer specialists were selected based on characteristics or qualifications that were strategic in relation to the study's research question (Thaagaard, 2018).

To obtain peer specialists for the study, team coordinators in FACT were contacted by mail. The coordinators took responsibility for establishing contact between the researcher and the peer specialists. An email was sent out to the coordinators describing the project and a desire to get in touch with peer specialists. Furthermore, I received a reply with the email to the peer

specialist. New email with information was sent to the peer specialist. Twenty teams were contacted, ten peers responded positively and three peer specialists withdrew before the interviews. Table 1 shows the socio-demographic profile of the sample.

The aim was to recruit 10 interviewees. The choice fell on 10 interviewees due to the time frame of the study, the resources available and the view that this would give sufficient data on which to base a thorough analysis of themes. In qualitative research the sample size can be small as it does not aim to be statistically representative and therefore cannot be used to generalize or represent all peer specialists. However, the aim is to generate rich data from small samples.

A pilot interview was conducted. This involved an instructive exercise to test out the interview guide, as well as practicing myself on the interview situation. Only minor adjustments were made in the interview-guide after the pilot but the rationale for the interview became set and tested.

At the start of each interview, information about the project was provided together with the information sheet and of the informed consent form was sent the interviewees by mail (Appendix 2 and 3).

Table 1: Socio-demographic profile of interviewees recruited to the study

Interviewees	**Sex**	**Previous employment or educational level**
Interviewee 1	Female	Hairdresser
Interviewee 2	Male	None
Interviewee 3	Male	Welder
Interviewee 4	Male	Did not say
Interviewee 5	Female	None
Interviewee 6	Female	Bachelor degree
Interviewee 7	Male	None

3.3 Conducting the interviews

The interviews were done in the spring of 2021. All the interviews were initiated with a briefing, so I could try to gain a trusting atmosphere and make a good relationship with the peer specialists. I started by briefly talking about myself, as well as asking the peer specialists about their age, gender, level of education and their background. Furthermore, I informed them about the purpose of the study and on the various topics that would be highlighted during the interview. I went on to say that it is their reflections on being a peer specialist I am interested in and that there are no right or wrong answers. I conveyed that the interviews were confidential, and that all analysis and presentation of the interviews would be done anonymously.

Kvåle and Brinkmann (2009) suggests a debrief after the interviews. Therefore, the peer specialists were asked if they had anything more to add, why they wanted to participate, as well as their experience of being interviewed.

3.4 Analysis of the interviews

All interviews were transcribed verbatim. Thematic analysis, as an analysis tool, was used. Thematic analysis is one of the most common approaches to qualitative data analysis (Bryman, 2016). The method involves identifying, analysing, and reporting patterns and themes in the data material (Braun & Clarke, 2006). The researcher has a social background and experiences that can influence the perception and understanding of what is being studied, therefore objectivity and value neutrality, consciously or unconsciously, was always a topic of critical reflection (Barret, Kajamaa & Johnston, 2020). In contrast, the interactionist and constructive perspective is seen as a key point in the perception that the results of the research are characterized by the interaction between researchers and participants in the field. The understanding that the researcher develops is based on a collaboration between researcher and participant through which the data is generated and subsequently analysed. Based on the contact during the fieldwork, the researcher develops an understanding of the participants' views of their situation, the perception they have of their experiences and how they interact within the social context to which they belong, in this case, other members of the multidisciplinary team in particular. The meaning of the phenomena studied by the researcher is rooted in a reconstruction of participants' experiences (Thagaard, 2018).

In achieving more depth in qualitative research, it was desirable to promote reflexivity as a continuous process to improve the quality of research. Being a reflexive researcher involves carefully assessing each step of the research process. Alternative perspectives that may be contrary to one's own were also considered. A hallmark of good research in any paradigm is methodical strength and by qualitative research there is a significant strength to be both

reflexive and critical (Barret, Kajamaa & Johnston, 2020). Discussions with the supervisor supported reflection and reflexivity.

Data saturation, also defined as information redundancy, is one step in qualitative research where no new topics or themes emerge from already collected data. Braun and Clarke (2019) have operationalized the data saturation principle to provide concrete guidance on how many interviews should be included to achieve some data saturation in research using thematic analysis. As Buetow (2010) says in his perspective, thematic analysis is characteristic of qualitative research (Buetow, 2010, p. 123) while Braun and Clarke (2019) question whether data saturation is a useful concept for thematic analysis in research or not (Braun & Clarke, 2019).

Once the interviews had been transcribed, the analysis process started with reading the transcripts to become more familiar with the participants' perspectives. The next stage involved coding the data. Coding the data is the first step in thematic analysis, after rereading the transcripted material (Bryman, 2016). The research question and the four objectives were used to guide and structure the coding process. The text was read, line-by-line, in order to identify units of meaning and label them with a code that gathers the meanings identified. Each transcript was coded in this way that meant it kept close to the text of each interview, giving labels (names) to those parts of the text that were important to each research question and objectives. How these codes re-appeared in the transcript as well as across the transcript was an important part of deciding if it should be labelled as a significant theme. The codes captured basic units of meaning in a descriptive way. The codes were built up further, became themes and contained a higher level of analysis. The themes said something important about

the data, and the topics highlighted the most prominent issues of importance presented in the data. The themes were labelled with names that captured large portions of the data and gave genuine insight into the research question. This process involved going backwards and forwards across the transcripts and reorganizing the codes into the themes in order to get the best possible understanding of participants' perspectives. The process of analysis was mainly inductive but was informed by the concept of empowerment.

The final step in the analysis involved a review of the themes identified by creating an explanatory framework based on the most important themes (Braun & Clark, 2006). Furthermore, the raw data material was reviewed several times, to see if significant perspectives had been omitted.

3.5 Ethical considerations

General research ethical guidelines and the Helsinki Convention are important governance documents in research ethics. Respect, consequences, fairness, and integrity are values that are emphasized specifically (Research Ethics Committees, 2018). These values were used to guide the research.

In this study, research ethics was especially important as the peer specialists were asked to talk about their personal life experiences and thoughts. Gaining insight into your own experiences and thoughts can be a sensitive area, especially if you have direct experience of drug use and/or mental health problems. The research ethics of Norway are based on three basic requirements that should be met in the form of ethical considerations. This consideration is a requirement for informed consent, privacy requirements and requirements to be properly

rendered (Jacobsen, 2010, s. 45). In qualitative interviews, it is important to safeguard the integrity of the persons interviewed both during the interview itself and afterwards, when the results are to be presented and interpreted. Researchers must anonymize recognizable details and treat sensitive information with caution (Fangen, 2015). The peer specialists were informed of the benefits and disadvantages of the study. They were also informed about anonymity and confidentiality of the information they were supposed to share. The information sheet and consent form are in Appendix 3 and 4.

This master's project was registered with the Norwegian Social Science Data Service (NSD) (Appendix 4), which is an agency that assesses whether the project meets the research ethical conditions (NSD, 2012).

Chapter 4 Findings

This chapter starts with a presentation of the four themes that were developed to understand peer specialists' thoughts and experiences. In order to structure the presentation of the findings, the four research objectives were used, which were the dimensions under which the interview-guide was built. One theme for each objective was developed (see Table 2 below). The four themes give together a nuanced answer to the research question of the study; *Working as a peer specialist I FACT: how do they make sense of their role?* The themes are presented with quotations from the interviews used to support the analysis. All participants were anonymised.

Table 2. The four research objectives and the four themes.

Research objective	**Theme**
How do peer specialists make sense of their role in relation to treatment and recovery?	**Experiencing identity-confusion**
How do the peers experience their position in an interdisciplinary team?	**Achieving respect and autonomy**
How do the peer specialists manage their own emotions?	**Receiving guidance**
How do the peer specialists handle their limits for self-disclosure?	**Personal integrity**

4.1 Experiencing identity confusion

Here, the research question *how do peer specialists make sense of their role in relation to the people they work with during treatment and recovery was explored by developing the theme of* "experiencing identity confusion". The theme particularly looked at the peer specialists' relationships with others in their team and how they fitted in with the other professionals.

One aspect of identity confusion related to the perceived importance of attending educational courses. As previously described, there is a 1-year education course to help prepare those with experience of drug use and/or mental health problems for employment as a peer specialist (those with so-called user experience, of MB). MB training gives mental health service users an opportunity to use their experiences and resources to work with others who have mental health problems. The purpose is for the service provided to be able to benefit from the experience that the users themselves have, in the same way as other competences. This came up as a topic of conversation among interviewees. A key dimension of peer specialists' perspectives related to the issue of whether such a course would change them in a way that they lost some of the value of being a user themselves. In other words, attending the course could mean that they became more like the other professionals in the team. Interviewee 2, for example, says that this was an education he would not have taken because he could not have done his job the way he liked to do it because he would have different frameworks to work with afterwards. In particular, he talked about how he thinks the role would be academic. It was not only the specific course in Bergen that was seen as problematic in terms of identity. The same was seen as applying if you had another kind of education, such as a nurse. The participants therefore perceived that they had some value or naturalness that would be lost through education. It can be difficult to do the job through two roles, when the job is as mentally demanding as it is. Interviewee 2 stressed that for him, the like-minded relationship with the patient would be gone.

It is common for the peer specialists to get courses and seminars throughout work, together with the rest of the team, which consists of everything from psychiatrists, psychologists, social workers, child welfare educators and nurses. Several informants pointed out that this everyday experience of working in a multidisciplinary team made it challenging not to be

influenced by the other professions in the team. Their identity as a peer specialists was thus over time difficult to keep. They said it could be challenging because it was sometimes easy to enter the role of a therapist. In this way, they saw it as very important for them to reflect on their identity and the value in their role and how to maintain it. For example, one informant says that he had realised he was becoming more professional by the years, but at the same time he did not want to change his face to his patients, it would change the relationship they have as equals. For the interviewee who had a Bachelor's in health communication, her educational background was perceived as influencing her to sit down as a therapist with the patients. This also created dilemmas for her between the value of her as a peer specialist and the professional aspect of being a therapist, which she felt needed reflection on all the time.

For example, one interviewee said:

> *"I think I've become more professional, safer in my job. But I don't want to change in the face of patients, or those with substance abuse problems, then I will not get the chemistry with them that I have today. Then I might as well go to school as a psychologist or a doctor or something"* (Interviewee 3).

The issue of experiencing this kind of identity confusion was also related to the fact that the role was very diffuse as there was an absence of any job description. This meant that the peer specialists perceived they had to shape their role as time goes on.

4.2 Achieving respect and autonomy over time

Here the research question *how does the peer specialists experience their position in an interdisciplinary team was explored.* The theme that was developed to understand peer specialist's perspectives on this issue was that of "achieving respect and autonomy".

An important dimension of this theme was that over time interviewees perceived that they received respect from other team members, and with that some autonomy to work as a peer specialist who was different from them. Feeling respected was reflected in how they felt listened to by others in the team. For example, one informant said that he was very lucky to have respect in the team he works in, and when he speaks out he is listened to and respected.

> "*It's rare that I feel set aside. The others often come to me asking for advice as well, it can be anything from how intoxication works or whether it has to do with housing."* (Interviewee 1).

Being listened to meant that those in the team came to have a better understanding of peer specialists' experiences. This also had the benefit of them being able to use peer specialists' experiences as well in their work. Being heard was thus perceived as important because it meant that others understood that peer specialists had something valuable to contribute that was different from others in the team. All in all, this meant that it was possible to have a unified strategy to help patients.

When asked about any pressure to share personal experiences relating to their own drug use in order to gain entry or autonomy for the peer specialists role in the team, this was seen as a

necessity, especially in the beginning, as this was the only way for team members to gain an insight into how peer specialists could be used in the course of treatment of the patients.

> *"The first thing a team member asked me was if I could tell my story. I was quite put out, and dared nothing but share. It felt very strange."* (Interviewee 6).

There was also a perception among peer specialists that they often felt there was some curiosity from employees outside the team that they had to deal with. For example, one interviewee said:

> "*It is with the others in the clinic beyond the team that I feel the most about that I work as a peer specialist. I don't have the big great papers they have, so for them it's maybe a little strange that there's an ex-drug addict walking around the hallways working."* (Interviewee 3).

Peer specialists felt lucky to be respected and able to have autonomy in the team. This was especially the case when they spoke out and they were listened to and respected. They tended to describe this as being incredibly lucky. This meant that they felt there was plenty of room for them in the team, whether it was professionally with other team members or with patients.

> "*I definitely feel like someone in the team. I get taken into account, they listen to me and include me in everything."* (Interviewee 7).

One interviewee who described herself as shy type and was very quiet at first, when she started the job. However, she became confident in the team over time and then realized that there was room for her and her opinions. Being accommodated as a team member was

important to peer specialists because they perceived they had a lot of knowledge that no one else in the team had. For example, one interviewee said:

> *"It's rare that I feel I'm set aside, and it's up to us peers to be forward and dare to say our opinion. The others in the team often come to ask me for advice as well, I know a lot about how drugs work"* (Interviewee 6).

4.3 Receiving guidance

Here the research question *how does the peer specialists manage their own emotions was explored*. The question was understood in terms of the theme "receiving guidance". Overall, guidance was seen as valuable in that it made peer specialists feel like a wiser person after an appointment of guidance. They also perceived that they in particular needed the space to off-load at the end of a day or week and make sense of all that had happened.

Within the drug field, there are major differences in practice, thoughts and opinions around guidance. This was also reflected in interviewees' experiences of everyday work, in terms of if they received guidance and if they did, who provided it and how often it occurred. One informant had a social worker and a psychiatrist who were her regular supervisors. Guidance was here based on a flexible model involving no fixed appointments, but being able to ask for it whenever she wants or felt the need.

> "*After a counselling session, I feel like I'm going out as a lighter and wiser person, and we can do this whenever we want. It feels really good."* (Interviewee 1).

Guidance, however, was not available to all interviewees. For example, one informant expressed that she would like to have guidance to make her feel less alone in her everyday

job. She expressed this as it being tough to use herself and her own experience in her role as a peer specialist and she needs a place to receive guidance on how to let go after work.

> "*It can be quite difficult days at work and I am often reminded of my own bad times. It would be nice to have a place where I could talk about this."* (Interviewee 6).

There were also examples of where the offer of guidance had been turned down. One interviewee, for example, perceived it as unnecessary because he had a lot of other people to lean on, although there were days when he struggled. A further reason why peer specialists did not receive guidance was that they were not offered any but had alternative ways of receiving support. For example, interviewee 4 had no offers of guidance through work, but had a sponsor that he could talk to. The need for some form of guidance was perceived to be especially important when patients' stories were like their own. For example, one interviewee said that at times he had to air his head and was very glad he had guidance.

> *"I have no guidance through work, for myself. We have guidance for the team, once a month. It would be good to have one for me. Some of my meetings with patients are exhausting. I use my own experiences as a tool in my job, and I need a filtering space afterwards. I work with a lot of skilled therapists, but it won't be the same to talk to them. Even though I know they're looking out for me"* (Informant 6).

4.4 Personal integrity

The research question *how the peer specialists handle their limits for self-disclosure* was understood in terms of the theme of "negotiating self-disclosure". An important dimension of self-disclosure was that it often needed ongoing negotiation with oneself, over time and in relation to different aspects of one's life.

Self-disclosure was a topic that also divided opinions among the peer specialists. A central issue relating to negotiating self-disclosure was that of how to keep the peer specialist feeling secure whilst also being able to fulfil their role with the patient. This often required a lot of reflection. One interviewee, for example, explained that it was important to feel safe that she can self-disclose but she had moved away from doing so because she had come to the view that performing the role was not about her anymore but about the patients. However, on occasions when somebody asked, she would self-disclose. For other peer specialists, self-disclosure became difficult when they met themselves at the patient's door. In these circumstances, because it was very close to their own story, it was difficult to relate to.

Other interviewees were more proactive in self-disclosure because they saw it as an important resource in their role as a peer specialist. For example, interviewee 2 viewed his broad experience with substance abuse, anxiety, depression and isolation, which he had learned to use with patients. This was similar to others who did not see a problem in sharing about his past, before he went into substance abuse treatment. For some interviewees, however, some areas of their lives were 'private' and not open for sharing. For example, one interviewee stated that he did not talk about his life as it was today, nor about his family and his children. There he was holding back.

> "*Some of the patients see me as a buddy and I can share quite a bit from my past. Today I have a partner and children and do not give out names of them or where I live."* (Interviewee 4).

An aspect of self-disclosure that was spoken about was the way in which in the beginning if felt 'natural' to talk about one's one experiences. For example, one interviewee expressed how quick and a little intense it was at first, because "*it became so natural to share my own experience"*. He wanted to share so badly. It was only over time that peer specialists learned some of the skills of filtering out what they could or would share. After having worked on developing these skills it became easier to filter and use self-disclosure a little more carefully, instead of constantly trying to share.

One aspect of self-disclosure that interviewees talked about was that sharing even some of the worst personal experiences had an important role in creating trust with patients. Alongside this was a perception that a core part of the role of being a peer specialist was that having lived the life that they had done, and today he had a permanent job, a car, and an apartment, and a fixed income, was what gave hope to the patients. For example, one interviewee said:

> *"They understand that I have lived hard, and it creates a trust, in the same way as the trust one gains in a substance abuse environment. So, recognition, I think that's the most important thing, it creates an extra good relationship"* (Interviewee 7).

Chapter 5 Discussion

This thesis set out to explore how peer specialists experience their everyday working lives, which has been little explored in Norway and elsewhere. Overall, the research has revealed that although the introduction of peer specialists into multidisciplinary teams in Norway is a relatively recent issue, there are signs that this is working well from their point of view. In this regard, integration into a team as a peer specialist seems to be accompanied by experiencing various degrees of empowerment directly relating to their perceived autonomy and the respect this makes them feel. Receiving recognition for their experience and feeling it is valued as something that would otherwise not be present in the team can be understood as an important aspect of peer specialists feeling empowered. Some other issues were also uncovered, which are explored further below.

5.1 Experiencing identity confusion as a peer specialist

The experiences of those in the role as a peer specialists vary and so too do their perceptions. There is, for example, some disagreement about whether it is wise to take the study "employee with user experience" which can be obtained in Bergen, and questions are raised about whether a peer is too schooled, too academic with this education to the extent that they become less a peer specialist and more like other members of the team. Weber and Jensen (2016) write that health professions are apparently experts in their areas. The same is the case with the peer specialist, who is an expert in his/her arena, because they have been through the experience of treatment and/or use of drugs. However, it may not be as simple as it sounds to integrate a peer specialist without a formal qualification. But the dilemma remains in that formal qualifications may reduce the extent to which peer specialists can offer something of direct significance to patients and that is different from what other members of the multidisciplinary team offer. Patients may be able to better identify with a peer specialist and

therefore engage with treatment and recovery services. Nonetheless it is likely that peer specialists will require some form of preparation for their role. What that should be, however, might need further discussion.

Although gender issues did not come up in the empirical data in this study, Weber and Jensen (2016) state that achieving gender equality in an interdisciplinary team where a peer specialist is employed can be a challenge. It can thus be questioned whether a peer specialist is equipped to fit into a team with a hierarchy and might be stigmatised as a result. At the same time, Franke et al. (2010) say that the more a peer specialist is schooled, the more they can move away from the role of peer specialist. Findings from this study show that there are divided views about the need for the education of "employee with user experience", in the same way as the findings of Weber and Jensen (2016) and Franke et al. (2010). In addition to the topic of education as a peer specialist, one works closely with the other professions in the team, such as psychiatrists, psychologists, nurses and social workers. Is there reason to believe that as a peer specialist you will put on the white coat and lose the attribute you think a peer specialist possesses? Putting on the white coat as a peer specialist can be easy to do as this and other research has suggested. Alberta and Ploski (2014) state that peer specialists working in treatment organizations are subject to processes of acculturation into professional cultures that peer staff working in peer organizations are not. They say that an effective implementation should include specific efforts to minimize the co-optation of peer staff, that is, efforts to keep and develop the unique identity of the peers, also in an organization dominated by professionals (Alberta and Ploski, 2014). As Weber and Jensen (2016) say, it is very important to be validated as the role of a peer specialist, also to be clear about how to get the best use of and integrate the role into the team. Is it possible that following an educational course will make the peer more aware of the role? It is agreed among the interviewees that it

is important to use the role of peer specialist correctly, that is to say, according to their experience as a peer, and they constantly must reflect on the role as it is easy to slide into taking on the role of therapist. At the same time, it is agreed among the informants that the role of peer specialist is very diffuse and there is an absence of a work description.

5.2 Achieving respect and autonomy as a peer specialist

Peer specialists can face discrimination from professional staff and be exposured to stress. Peers can meet scepticism and prejudice that make them not function well in work (Weber & Jensen, 2016). However, in this study, there was a common consensus among the interviewees that they were well received in the team and that there was room for their perspectives and the knowledge they had through their personal experiences. They all felt that they were respected and heard, and they were taken seriously. Some of the interviewees perceived they had encountered wondering glances and curiosity from others in the health trust outside the team they worked in. They felt uncomfortable about this, and at the same time they were unsure if this was only one feeling inside themselves. It may, however, indicate that acceptance is more difficult beyond the team. The findings are similar to those of Mulvale et al. (2019) and Franke et al. (2010). Mulvale et al. (2019) state that the leaders in health enterprises must actively inspire a vision for the integration of peer specialists as part of the enterprises and that the adoption of peers requires a culture change that takes time (Mulvale et al, 2019). Franke et al. (2010) also say that some peer specialists experienced strong barriers to being accepted in the team, that the peers had to work hard to change the attitude of some of the staff, which had implications for the wellbeing of the peers (Franke et al, 2010). The existing workplace hierarchies could give rise to peer specialists feeling stigmatised and feeling like outsiders (Mulvale et al, 2019). Davidson et al. (2012) also said that integrating peers and adopting experience skills into a health enterprise involves changes

in both culture and practice in the services, and there are several challenges related to that (Davidson et al, 2012). The findings from this study suggest that the peer specialists were working in a culture that had adapted and accommodated their involvement, although this might not extend beyond the specific team.

5.3 Receiving guidance as a peer specialist

Mowbray et al. (1998) said that lack of support from supervisors was an added barrier for the peers (Mowbray et al, 1998). There was some diversity in the views of the interviewees regarding guidance in this study. This point can be related to the point above about the role of education in preparing peer specialists for their role or if it can lead to them becoming too academic and moving away from the core of the peer role. Guidance on the other hand can perhaps support peer specialists without such education to adapt to their role while at the same time maintaining their expertise as a peer. Other findings show that education can provide a safe base in an otherwise challenging landscape. Mulvale et al. (2019) argues that leaders must prioritize guidance for peer specialists and back this up with action (Mulvale et al, 2019). It is very important for the peers to extend health benefits, such as guidance, to support their own health. Basically, peer specialists can have a sense of incompetence and lack of confidence in working in a multidisciplinary team. The findings from the current study are similar but indicate that over time they experience acceptance and this strengthens their view of themselves. Peer specialists can often experience a stressful environment that creates mental unrest, that goes beyond the actual work that the peers will perform for patients (Ibrahim et al, 2019). Furthermore, Holst and Mohn-Haugen (2021) showed in their survey that peer specialists lack guidance. Several missed individual guidance and guidance in general and some wanted closer follow-up from the employer where there was increased focus on self-care, ethics and on relatives (Holst and Mohn-Haugen, 2021). Trane (2020) says

that the education in Bergen aims to qualify the participants for work in mental health care, where guidance is a central part of the course (Trane, 2020). The findings from this study are similar to these findings in that peer specialists need support in one form or another. The key is to ensure that all can access some form of guidance as this seems as an important aspect of supporting them to carry out a demanding role.

5.4 Negotiating self-disclosure as a peer specialist

The findings suggest that peer specialists feel like there is some pressure to self-disclose, talking about their ups and downs as if everyone have the right to know their private matter. They had experienced demands to reveal personal details with other team members that were not usually expected of other professionals. The peer specialists in this study felt a lot of shame from the time in their lives consisting of painful memories, some of them also having lost friends and family. They had experienced deaths in the environment they lived in. They had directly experienced being medicated, going in and out of treatment institutions. Some of them questioned if it was justifiable, or ethically correct, that they must go back down memory lane. Ibrahim et al. (2019) said that if there was an uncertainty about level and limits of self-disclosure, it could also create a mismatch between the expectations of the employer and the peer specialist (Ibrahim et al, 2016). It is just like Fleiner (2016) said, that the role could be very demanding, because the expectations are so colossal for these positions both from the employers, from the user environments and from colleagues in the academic community (Fleiner, 2016).

The findings show that self-disclosure is a topic that the peer specialists had differing views on. There was some consensus that they do not have to hand themselves out. However, peer

specialists' views varied on whether one should or not. There was also disagreement about whether self-disclosure had any bearing on how well relationships with patients were formed. Among the interviewees, those who tended not to share were those who had attended the study "employee with user experience" in Bergen. Ehrlich et al. (2017) note that the role is very diffuse (Ehrlich et al, 2017) and therefore unclear on the boundaries of self-disclosure. The interviewees in this study said that they enter the role with a lot of shame. Self-disclosure is part of a process through which they re-experience that shame and if this is the case then it threatens their safety and security. Drawing on Freire's basic thesis about humans' goal to seek a richer human dignity (Freire, 2007, p. 24), the peer specialist role could be a route for achieving this. However, this is to some extent dependent on how self-disclosure is negotiated and, relatedly, how guidance and other forms of support can help them negotiate this aspect of their role. The findings from this study suggest that over time peer specialists learn the skills of self-disclosure in a way that enables them to keep themselves safe. However, the demands of this aspect of the role were evident.

5.5 Limitations of this study

This study has some limitations. First, the sample size is small. Second, the selection of subjects is within FACT, further narrowing the generalisations available from the study. Limited experience among the subjects as peer-specialists is also transferred over to the results and participants have demonstrated a somewhat narrow comprehension of education and development in the field, for example the course in Bergen.

Chapter 6 Reflection and conclusion

This study aimed to provide a deeper insight into the thoughts and experiences of peer specialists related to their roles in an interdisciplinary team. It was desirable to get a better understanding of how a peer specialist experiences their role. Other countries have come further in both the use of a peer specialist in the drug field and with research of the role, and therefore much of the references in this study is sourced from other places than Norway. However, as explained earlier, Norway is in growth with the use of peer specialists, and only just a few studies have been done on this theme. This study shows that peer specialists are well accepted in the team, without feeling stigma, and at the same time there are curiosity about the role of other employees in the health enterprise. Some allude to feeling insecure in their role to begin with and growing with the task.

As referred to earlier in the text health enterprises that require education within the peer specialist role have shown that they are more likely to succeed in integrating the peer specialist. They have also shown that if they show leadership they can also help other employees of the enterprise to have greater understanding of the role and embracing its importance. This suggests that there may be some value in debating the requirement for an educational qualification for becoming a peer specialist. Relatedly, given the diffuse nature of the job, a more detailed job specification might be of value in helping peer specialists adapt to their role. Involving peer specialists in this work could be important.

One challenge that remains is guidance to the peer specialist. This is no 8-16 job as you never get time off work, because the work involves one’s feelings about one’s own experiences, which are important tools in the position. It is easy to get “eaten”, and earlier studies show

that peer specialists desire to be looked after more in the form of guidance. This might change with prior education but there is still likely to be a need for ongoing guidance to support peer specialists.

Contrary to previous perceptions of treatment, most professionals today consider that relapse into drug use is normal and expected (Holte, 2015). Then relapse can also be considered as expected in a peer specialist employed based on their own drug experience. With a challenging everyday life as a peer specialist, where they use the toughest periods of life as a tool, who feel shame and lack guidance, it is easy to conclude that the chances of relapse increases. What then happens if a peer specialist with in-depth knowledge of patients at the treatment institution resumes use of illegal drugs? This raises a number of important questions that go beyond the specific focus of the current research but are nonetheless important for consideration in the arena of employing peer specialists. For example, Is the person expected to be integrated as a client or patient who will receive treatment from former colleagues? How do you deal with the risk of the peer specialist participating in drug-related activities with his or her previous patients after relapse? And what happens to the trust and the relationship between the patients and the peers? During the course of this study, many new questions have arisen in relation to the role of peer specialist. A lot of focus has been placed on what can be positive about the role, and there is a lack of studies that shed light on the hidden parts and long-term consequences, both for the peer specialist and the patient. Psychologist and senior lecturer at VID Specialized University, Liese Recke, says that in the meeting with the peer specialists, patients have doubts about whether they should regard the person concerned as a responsible professional or as an equal person with whom they should have solidarity with. They are therefore even more uncertain about their own rights, position and what expectations they may have for the relationship. At the same time, they may risk meeting and interacting

with the peer specialist in other unregulated/privatised contexts and therefore may strive to preserve harmony in the relationship (Skjeldal, 2021). At the same time Bellamy et al. (2017) says that there is a reduction in relapses and symptoms in patients that prove it is highly effective in drug treatment to use peer specialists (Bellamy et al. 2017).

Skjeldal (2021) highlighted under-communicated challenges when hiring peer specialists who will work in a user-oriented way. Furthermore, it is appreciated that professionals are subject to requirements and rules and may lose their authorisation, but that the peer specialist is not required other than a compelling turning point story. Skjeldal (2021) also said that peer specialists in the field of substance abuse mix working hours and leisure time and interact with the same patients both as professionals and as equals (Skjeldal, 2021). One interviewee shared this as a challenge, where he works in the same environment as he himself was in, in active intoxication.

In my work on the master's thesis, I have gained more insight into how the role is understood by the individual. I am grateful to have been able to take part in the peer specialists' thoughts and experiences regarding the role they have in an interdisciplinary team and in meetings with patients. It would be interesting to have a follow-up study to investigate how the role of peer specialist will be integrated into a health enterprise with prior education. This study shows it can be advantageous to have the education "employee with user experience" as a basis for being safer in the role, together with a prepared work instruction from the health enterprise at the start of the working relationship. However, this was not a universal view.

After completing this master's thesis, I am left with the impression that a future intervention aimed at the guidance and education for the peer specialist will increase their quality of the role and quality of life, also in the form of self-disclosure of private experiences.

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Appendix 1 Intervjuguide

A. Veien til å bli brukerspesialist:

1. Kan vi starte med at du forteller litt om hvordan du ble brukerspesialist, hva er bakgrunnen din?
2. Hvis vi ser tilbake, kan du forklare hvorfor du ville begynne å jobbe som brukerspesialist?
3. Hvilke forventninger hadde du til rollen som brukerspesialist?
4. Hvor nyttig opplever du jobb beskrivelsen din i forhold til forventningene du hadde i rollen som brukerspesialist?

B. Realiteten med å jobbe som brukerspesialist i møte med brukere/pasienter

5. Hvordan opplever du jobben din i møte med brukere/pasienter?
6. Hvordan håndterer du grensene for selvutlevering?

C. Realiteten med å jobbe som brukerspesialist i et tverrfaglig team

7. Kan du forklare til meg hvordan arbeidet ditt er organisert?
    a. Hvem er i teamet ditt?
    b. Hvordan tildeles arbeidet?
    c. Hvor mye autonomi har du?
8. Hvis du reflekterer over teamet ditt, kan du si noe om hvordan du tenker at du passer inn og hvordan de andre «ser» deg?
    a. Hvordan ser du din kompetanse/rolle i relasjon med andre kompetanser/roller i teamet?
    b. Hvordan håndterer du dine grenser for selvutlevering med andre kollegaer?

D. Reflektere tilbake på din reise som brukerspesialist

9. Hvordan ser du din personlige og profesjonelle utvikling siden du startet å jobbe som brukerspesialist?

E. Avslutte intervjuet

10. Er det noe du ønsker å tilføre om rollen din som brukerspesialist som vi ikke allerede har pratet om?

Appendix 2 Informasjonsskriv

Jeg er i innspurten av en mastergrad, og skriver på oppgaven som skal leveres ferdig 23. Mai. Jeg går på skole gjennom Høgskolen i innlandet, avdeling Elverum. Der har jeg nå i 3 år på deltid studert Folkehelsevitenskap med vekt på livsstilsendring. I oppgaven min har jeg lagt vekt på brukerspesialistrollen.

Jeg ønsker å intervjue brukerspesialister i FACT team og har utviklet en intervjuguide med hjelp av veileder.

Informasjon om prosjektet: **Brukerspesialisten sitt perspektiv – hvordan forstår de sin rolle i arbeidssituasjonen**

Formålet med prosjektet er å belyse arbeidet en brukerspesialist utfører, og dens roller innenfor et helseforetak og i møte med pasienter. Det er i dag vage arbeidsbeskrivelser for ansettelser av brukerspesialist, hva som forventes i arbeidet og ikke minst grensene for selvutlevering av ens erfaringer, til både pasienter og til medarbeidere. Gjennom forskningstiden min er det også kommet opp et spørsmål i forhold til veiledning og ivaretakelse av brukerspesialisten.

Brukerspesialistene vil få tilsendt et samtykkeskjema og samtykkeerklæring sammen med informasjon om prosjektet, hvor rettighetene til intervjupersonene kommer frem i forhold til personvern. Dette skal signeres, og navnet til intervjupersonene vil komme frem, og vil samtidig bli behandlet konfidensielt. Intervjuet vil foregå på videomøte.

Jeg håper dere ønsker å bistå meg i denne oppgaven, og gi meg gjerne beskjed så raskt som mulig om dette er av interesse.

Mvh Wendy Kroksjø Tlf 97488805 / mail: wkroksjo@gmail.com

Appendix 3 Samtykkeskjema

Ønsker du å delta i forskningsprosjektet

«Brukerspesialister sine synspunkter, opplevelser og sin selvutlevering i en ansettelse i et helseforetak»

Dette er en forespørsel til deg om å delta i et forskningsprosjekt hvor formålet er å undersøke hvilke roller brukerspesialisten har i en ansettelse og hvilket arbeid som utføres. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål

Formålet med denne masteroppgaven er å få et innblikk i opplevelsene brukerspesialister har i sin ansettelse og i et tverrfaglig team, i forhold til roller og selvutlevering. Problemstillingen som ønsker å besvares er «Fra brukerspesialistens perspektiv - hvordan forstår de sin rolle i arbeidssituasjonen».

Hvem er ansvarlig for forskningsprosjektet?

Høgskolen i Innlandet er ansvarlig for prosjektet.

Hva innebærer det for deg å delta?

For å kunne fullføre masteroppgaven har jeg behov for å gjennomføre intervjuer med brukerspesialister i ansettelser. Varigheten på intervjuer vil ligge på cirka 30-60 minutter. Det vil foreligge et semistrukturert intervju som vil bli ført som en samtale mellom intervjuer og den intervjuende. Intervjuet vil bli tatt opp med lydopptaker på egen mobiltelefon. Opptakene sendes direkte til skylagring som er sikret for uvedkommende, det er kun forsker som har tilgang. Lydopptakene blir dermed ikke lagret på mobiltelefonen. Underveis i intervjuet ønsker forsker å ta notater.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke ditt samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ønsker å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil kun bruke opplysningene om deg til formålene vi har fortalt deg om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket.

Opplysninger som blir gitt under intervjuet vil kun være tilgjengelig for meg (student) og min veileder ved Høgskolen i Innlandet etter opplysningene er blitt anonymisert.

Navnet, kontaktopplysningene og eventuelt annet som kan identifisere deg vil bli lagret elektronisk i «Nettskjema» som er et dataoppbevaringsverktøy anerkjent av Høgskolen i Innlandet, Personvernforbundet og Regionale Etiske Komiteer.

***I det ferdige resultatet vil det ikke være mulig å gjenkjenne deg ut ifra opplysningene som kommer frem under intervjuet. Det vil nevnes i publikasjonen at utvalget er brukerspesialister i Øst-Norge. Det vil benyttes opplysninger som «Informanter». Dette skal gjøre at deltakerne ikke er mulig å gjenkjenne i publikasjonen.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?

Prosjektet skal etter planen avsluttes 21. Mai 2021. Intervjuopptakene og personopplysningene vil bli slettet ved prosjektslutt. Personidentifiserbare opplysninger fjernes slik at anonymisert data vil bli oppbevart seks måneder etter prosjektslutt. Dette hvis det forekommer at Høgskolen krever bevis om at forskningen er foregått.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- Innsyn i hvilke personopplysninger som er registrert om deg.
- Å få rettet personopplysninger om deg.
- Få slettet personopplysninger om deg.
- Få utlevert en kopi av dine personopplysninger (datadataportabilitet), og
- Å sende klage til personvernombudet eller datatilsynet om behandling av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?

Vi behandler opplysninger om deg basert på ditt samtykke.

Hvor kan jeg finne ut mer?

Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

Høgskolen i Innlandet ved **Student:** Wendy Kroksjø, mail: wkroksjo@gmail.com
Telefonnummer: 97488805. **Veileder:** Miranda Thurston, mail: miranda.thurston@inn.no

Med vennlig hilsen

Prosjektansvarlig (Forsker/veileder)

Student

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet «**Fra brukerspesialistens perspektiv - hvordan forstår de sin rolle i arbeidssituasjonen**» og har fått anledning til å stille spørsmål. Jeg samtykker til:

- € å delta frivillig i studiens intervju.
- € at opplysninger om meg kan brukes i publiseringen (anonymt).
- € at mine personopplysninger lagres etter prosjektslutt og deretter anonymiserte opplysninger frem til 21. november 2021.

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, ca. 21. Mai 2021.

(Signert av prosjektdeltaker, dato)

Appendix 4 NSD Godkjenning (ethical registration)

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Brukerspesialistens arbeid og roller - en utforskende kvalitativ intervjustudie

Referansenummer

317015

Registrert

17.02.2021 av Wendy Kroksjø - 222212@stud.inn.no

Behandlingsansvarlig institusjon

Høgskolen i Innlandet / Fakultet for helse- og sosialvitenskap / Institutt for folkehelse og idrettsvitenskap

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Miranda Thurston, miranda.thurston@inn.no, tlf: 62430276

Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

Wendy Kroksjø, wkroksjo@gmail.com, tlf: 97488805

Prosjektperiode

01.10.2020 - 21.05.2021

Status

22.02.2021 - Vurdert

Vurdering (1)

22.02.2021 - Vurdert

Det er vår vurdering at behandlingen vil være i samsvar med personvernlovgivningen, så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet den 22.02.2021 med vedlegg. Behandlingen kan starte.