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Tensions and Opportunities in Nurse, Midwife, and Peer Worker Collaborations in Healthcare Delivery: A Scoping Review and Narrative Synthesis

Olivia Hollingdrake[1] | Emma Paino[1] | Sarah Warzywoda[2] | Aaron Akpu Philip[3] | Judith A. Dean[2] | Christopher Howard[4] | Jo River[5]

[1]School of Nursing, Faculty of Health, N Block, Kelvin Grove Campus, Queensland University of Technology, Kelvin Grove, Victoria, Australia | [2]School of Public Health, Faculty of Medicine, Herston Campus, The University of Queensland, Herston, Australia | [3]School of Public Health & Social Work, Faculty of Health, O Block, Kelvin Grove Campus, Queensland University of Technology, Kelvin Grove, Victoria, Australia | [4]Queensland Council for LGBTI Health, Fortitude Valley, Queensland, Australia | [5]Faculty of Health, University of Technology Sydney, Ultimo, New South Wales, Australia

Correspondence: Olivia Hollingdrake (olivia.hollingdrake@qut.edu.au)

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ABSTRACT

Aim: To explore the published literature on nurse/midwife and peer worker collaborations in healthcare services.

Design: Scoping review and narrative synthesis.

Methods: The framework proposed by Levac et al. was used. PubMed, CINAHL, MEDLINE, Scopus, and Embase databases were systematically searched, and results uploaded to Covidence for screening against inclusion criteria. A critical narrative synthesis of included studies was conducted, guided by Popay et al.

Results: Sixteen studies from five countries met the inclusion criteria. They examined peer worker and nurse/midwife collaboration across diverse settings including cancer, HIV, mental health, and community services. Findings indicated that nurse/midwives and peer workers valued the distinct forms of expertise they contributed, which enhanced care. Tensions in collaboration related to clinical dominance and control in hierarchical structures, challenges navigating scope and role boundaries, and mistaken notions of what constitutes 'successful' peer work. Peer workers and nurses/midwives could be 'close strangers' with little opportunity to build genuine rapport.

Conclusion: Successful collaboration requires attention to power dynamics within healthcare cultures and opportunities to connect and understand each other's disciplinary expertise. Identifying strategies to optimise partnership and mobilise collective strengths has the potential to further enhance care.

Implications for the Profession/Patient Care: Peer worker or 'lived experience' roles within healthcare services have rapidly expanded. Our study highlights the benefits of peer worker and nurse/midwife collaborations and areas that require attention, including recognition of peer worker and nurse/midwife roles and responsibilities in the healthcare setting and effective integration of peer workers into existing healthcare teams. Importantly, strategies should be developed to address disparate power dynamics between nursing/midwifery staff and peer workers as these impact workforce relations and capability. Addressing these key areas will strengthen collaboration between nurses/midwives and peer workers, improve healthcare provision, and ultimately benefit service users.

Impact: This study highlights the tensions arising when nurses/midwives and peer workers carry out duties alongside each other, as well as factors that can promote effective collaboration. Successful collaboration in healthcare necessitates addressing power differentials, fostering mutual understanding, and providing the tools, training, and inclusive environments needed for nurses/midwives and peer workers to work together effectively.

Reporting Method: This scoping review adhered to the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) extension for scoping reviews.

Patient or Public Contribution: Our authorship team includes experts with experience in peer work and supervision of peer workers, and designing and implementing peer-led interventions within health and community service settings.

1 | Introduction

Peer support represents a potential revolution in the way health services respond to people experiencing distress, illness, or adversity. In the context of health services, peer support workers are people who draw on their own knowledge, wisdom, and experience of a physical health condition, mental distress, or social adversity to support others facing similar health and social challenges (Hilton et al. 2022). In Australia, peer support workers provide support to individuals, groups and whole communities via informal community roles or more formalised positions within health and human services (Bradstreet 2006; Davidson et al. 2006; Kemp et al. 2020). Hereto, solidarity and care in communities are referred to as 'peer support', and the term 'peer worker' is used to refer to those in formal paid or unpaid roles in health or human services. With strong grassroots and community foundations, peer worker roles are increasingly being incorporated into specialist areas of healthcare practice (Roennfeldt and Byrne 2021). Nurses and midwives (nurses/midwives) constitute more than half of the global health workforce (World Health Organization 2022) and often work alongside peer workers. Yet scant evidence exists on ways that nurses/midwives and peer workers can best collaborate within integrated healthcare teams (Hurley et al. 2016). This scoping review identifies and summarises the existing literature on nurse/midwife and peer worker collaboration in health service delivery. It identifies the strengths of working together, the tensions that arise, and the opportunities to enhance collaboration that will benefit service users.

Recently, peer worker roles have rapidly expanded in health services, and positions now exist across peer-led services, nonprofit organisations, and private and publicly funded health services (Kemp et al. 2020; Paino et al. 2023). Peer worker positions are also dynamic and evolving; for example, peer workers have increasingly been employed to support an aging population of people living with HIV, who are now navigating mainstream aged care health services (National Association of People with HIV Australia 2019; Øgård-Repål et al. 2022). Peer support is founded on the principles of reciprocity, mutual respect, and equality, as well as the knowledge that people who have shared backgrounds and experiences have unique resources to offer each other (Krulic et al. 2023; Mead et al. 2001). Peer workers intentionally bring to their roles the insights acquired through personal lived experience and knowledge of community needs (Kemp et al. 2020). In contrast to other healthcare professionals, peer workers meet people as equal partners in a peer relationship, providing an opportunity to create meaningful connections through mutual, transparent and transformative dialogue (Repper and Carter 2011).

Evaluation of a peer work program, which supported service users to transition from mental health services to the community, found that compared to standard care, support from a peer worker was associated with a 32% reduction in hospital readmission within 28 days of discharge, 8.6 fewer days in hospital over a 12-month period, a 13% increase in reported recovery, and a net economic saving to health systems of $12,211 per service user (Hancock et al. 2021). Programs incorporating peer workers have demonstrated enhanced engagement and treatment uptake, particularly with service users who experience challenging or stigmatising conditions or circumstances, including HIV and other blood-borne illnesses (Grebely et al. 2023; Griffith et al. 2019; Keats et al. 2015; Krulic et al. 2022; Silano et al. 2022), mental distress (Parker et al. 2021; Thieling et al. 2022) alcohol and other drug dependence (Meumann and Allan n.d), and incarceration and homelessness (Nyamathi et al. 2016). Peer worker roles also extend to the provision of support for service users and caregivers in diverse healthcare contexts, for example cancer (Kinnane et al. 2011), neurological disorders (Fleisher et al. 2023), and neonatal intensive care (Macdonell et al. 2013).

In some contexts, such as HIV and hepatitis C, assisting service users to engage with biomedical treatments may be considered a key aspect of peer worker roles (Hilton 2021; National Association of People with HIV Australia 2020). However, peer work roles benefit individuals and communities in more ways than supporting engagement and treatment uptake (Hilton 2021). Peer workers can also promote social justice and equity, and can contribute significantly to the wellbeing, safety and rights of people in their communities (Hilton 2021). Indeed, being met by a peer worker, as a peer, rather than a list of symptoms, diagnoses, or problems can be a novel and transformative experience for health service users (Kemp et al. 2020). Peer-to-peer dialogue offers a shared experience and language, which can be highly protective against alienation and isolation, and also assists in navigating stigma and discrimination (Kemp et al. 2020). Peer support can increase peoples' social networks and cultural connection, and support access to housing, education, and employment opportunities (Davidson and Guy 2012; Grey and O'Hagan 2015; Hancock et al. 2021; Sledge et al. 2011).

Despite these benefits, healthcare teams are often unaware that peer worker roles exist or have a poor understanding of the function, ethos and value of peer work (Hurley et al. 2016; Krulic et al. 2022). Nurses and midwives are the largest health workforce

Summary

- What does this paper contribute to the wider global clinical community?
  - This scoping review provides a critical analysis of existing literature to highlight the strengths and tensions of nurse/midwife and peer worker collaboration in healthcare delivery.
  - Nurses/midwives may inadvertently co-opt peer workers into clinically based tasks that limit the independent scope of peer practice.
  - Successful collaboration in healthcare necessitates addressing power dynamics, fostering mutual understanding, and providing the tools, training, and inclusive environments needed for nurses/midwives and peer workers to work together effectively.

globally (World Health Organization 2022). Although nurses/midwives interact with peer workers in frontline services and may be tasked with their supervision, there are few opportunities for collaboration, including interprofessional training and strategic planning. Research indicates that nurses may harbour negative attitudes about peer work, for example, a belief that peer workers may transgress professional boundaries (Debyser et al. 2018; Vandewalle et al. 2016). Nurses/midwives and peer workers may risk working in silos when teams are hastily put together, lacking role definition or experiencing role overlap (Vandewalle et al. 2016).

Our own research has noted nurses' and peer workers' requests for more attention to productive ways of working together (Kemp et al. 2020). Strengthening collaboration between peer workers and nurses/midwives is vital to maximise the benefits of peer worker roles, which will ultimately enhance care for service users. Yet, to date, no review exists on how nurses/midwives and peer workers collaborate, including the barriers and opportunities that exist.

2 | The Review

2.1 | Aim

This scoping review and narrative synthesis explores the ways that nurses/midwives and peer workers collaborate. It identifies and critiques the breadth of available literature to determine, across diverse healthcare settings, the tensions and benefits of working together and how nurses/midwives and peer workers perceive each other's roles. In light of the limited research in this area, a scoping review was chosen as it allowed us to explore and map evidence and concepts (Munn et al. 2018) on peer worker and nurse/midwife collaborations across a broad range of studies and contexts.

2.2 | Design

This scoping review uses the steps proposed by Levac et al. (2010), including identifying a research question, searching for relevant studies, study selection (inclusion and screening), data extraction and summarising the data (Levac et al. 2010). Levac et al. (2010) suggest a stakeholder consultation as a sixth and optional stage. Given the focus of this review (nurse/midwife and peer worker collaboration) and the significant influence of reviews on policy and service planning, our team determined that a more collaborative approach to the review, that brought nurses, a midwife and peer workers together, was called for. Therefore, this review was undertaken by nursing, midwifery and public health academics in collaboration with peer workers. Two peer workers were invited to contribute their expertise on the peer work discipline and practice. CH was consulted in the research design and manuscript drafting and EP was employed as co-researcher on the project, undertaking collaborative analysis and critique of included studies. Both have expertise and extensive experience of peer work in HIV and mental health respectively, including overseeing and researching peer work programs at service and organisational levels, training peer workers and working as a peer worker in health services. To ensure equitable contribution, academic authors avoided the use of research jargon and discussed the study methods and findings in plain English. This is a measure that the academics have used previously in industry-engaged research.

2.3 | Search Methods

This scoping review adhered to the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) extension for scoping reviews (Tricco et al. 2018). The search strategy was developed by the authorship team (OH, SW, AAP) in consultation with a research librarian and consisted of frequently used terms relating to the PCC mnemonic (Population Concept, Context). Search terms included peer work, nursing (population), collaboration, teamwork and multidisciplinary teams (concept) and health services (context), which are displayed in supplementary file S1. In July 2023, five databases were searched systematically (PubMed, CINAHL, Scopus, MEDLINE, Embase) by combining the identified search terms using Boolean operators AND/OR, with results imported into Covidence systematic review software (2023) where duplicates were removed. A second search was completed in September 2024, with no additional studies identified that met the inclusion criteria. A citation search of the included studies was conducted to capture potential studies missed in database searches.

2.4 | Screening and Inclusion and Exclusion Criteria

Title and abstract screening were completed by two authors (OH and SW), who are public health and nursing academics respectively, with conflicts resolved through discussion with a third author (AAP), a public health academic. Full text review was then completed by the same two authors (OH and SW), with discrepancies discussed as a group with the third author (AAP) until agreement was reached.

Inclusion Criteria:

- Primary studies with results related to collaboration between nurses/midwives and peer workers (paid or volunteer) in healthcare service delivery.

- Studies of both employed nurses/midwives and nursing/midwifery students.
- Studies that assessed peer work in any healthcare services model.
- English language.
- Peer reviewed.
- Studies published between January 2000 and present.

Exclusion Criteria:

- Studies that only described the outcomes of collaborative services or contained results about nurse/midwife or peer worker without mention of collaboration between the two.
- Studies where nurses/midwives or peer workers were part of the research team but did not collaborate in health service delivery.
- Studies describing peer-to-peer interaction among nurses or midwives only.
- Conference abstracts, study protocols, thesis/dissertations, discussion papers

2.5 | Quality Appraisal

We undertook a critical appraisal of included studies to enhance the trustworthiness of the synthesis. Each study's quality was appraised by two authors (OH and AAP) using the Mixed Methods Appraisal Tool (Hong et al. 2018). The critical appraisal summary is presented in supplementary file S2.

2.6 | Data Abstraction and Synthesis

Descriptive details of the final papers were abstracted using Covidence and exported to an excel document to form a matrix table by authors OH and SW. Subject headings of the data extracted are detailed below in Table one. Authors OH, JR and EP then undertook a narrative synthesis of included study findings, following the guidance provided by Popay et al. (2006) to ensure a systematic and transparent approach to the analysis. Narrative synthesis adopts a textual approach to the process of analysis to 'tell the story' of the findings from included studies in order to draw conclusions based on the body of evidence (Popay et al. 2006, 6). We focused our analysis on research findings related to peer worker and nurses/midwives working together within health settings, which were coded and categorised by OH and JR with themes identified. These themes were collaboratively reworked and refined over a series of six meeting involving (OH, JR, and EP). This approach helped us to highlight and critique the contextual and temporal factors that influence nursing/midwifery and peer worker collaborations in healthcare service delivery, including the resulting successes, tensions or limitations of that collaboration. Proposed themes were then reviewed in collaboration with peer workers to refine and finalise, including EP and CH and these were presented in the results.

3 | Results

Database searches yielded 3055 results, of which 1783 duplicates were removed. Title and abstract screening removed a further 1131. Of the remaining 141 articles, 125 were excluded based on eligibility criteria, leaving 16 included for final review (Figure 1).

3.1 | Study Characteristics

Table 1 summarises the 16 papers included in the review, which report 14 discrete studies published between 2004 and 2023. Table 1 presents information using language that matches that of each individual study; for example, a mental health setting may be described as a psychiatric hospital. Two of these studies have findings reported in two separate articles (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Munns and Walker 2015, 2023). Six of the 14 studies were from Australia and the remainder were from the United States of America ($n=3$), Canada ($n=2$), the United Kingdom (including England and Wales) ($n=2$), and the Netherlands ($n=1$). Eleven studies used qualitative methods and the remaining two used mixed methods (Bergin et al. 2016) and quantitative descriptive design (Smeulders et al. 2007). The studies were based in diverse contexts including oncology services (Bergin et al. 2016; Ferville et al. 2023; Huntingdon et al. 2016), an HIV service (Enriquez et al. 2013), mental health services (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Foster et al. 2020), spinal injury care (O'Dell et al. 2019), cardiac rehabilitation services (Smeulders et al. 2007; Winder et al. 2004), neonatal intensive care unit (NICU) (Rossman et al. 2012), remote Aboriginal Community health services (Munns and Walker 2015; Munns and Walker 2023) inner-city health services for 'street involved' women (Mill et al. 2012), and community programs for women and people who are infant feeding (Cramer et al. 2017; Curtis et al. 2007).

Peer worker roles also varied. As Table 1 shows, eight studies described peer workers in paid positions, three included peer worker volunteers, and the remaining five studies did not state whether peer workers were in paid or volunteer roles. Language was inconsistent across included papers, with peer worker roles referred to as peer support providers (Huntingdon et al. 2016), peer support workers (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Foster et al. 2020; Mill et al. 2012; Munns and Walker 2015; Munns and Walker 2023), peer support officers (O'Dell et al. 2019) peer counsellors (Rossman et al. 2012), peer volunteers (Bergin et al. 2016; Cramer et al. 2017; Curtis et al. 2007), peer advisors (Winder et al. 2004), peer leaders (Smeulders et al. 2007), lay peer educators (Enriquez et al. 2013), accompanying patients (Ferville et al. 2023) and, in the context of infant feeding peer work, they were referred to as "Breastfriends" (Curtis et al. 2007). The diversity of terms used to describe peer work reflects the diversity of understanding among health and community services about who peer workers are and what their roles involve. Hereto, all paid or volunteer peer worker roles with other titles, for example, peer volunteers or peer counsellors, are discussed collectively as peer workers. Two studies included midwives (Cramer et al. 2017; Curtis et al. 2007), with the remainder focused on nursing only.

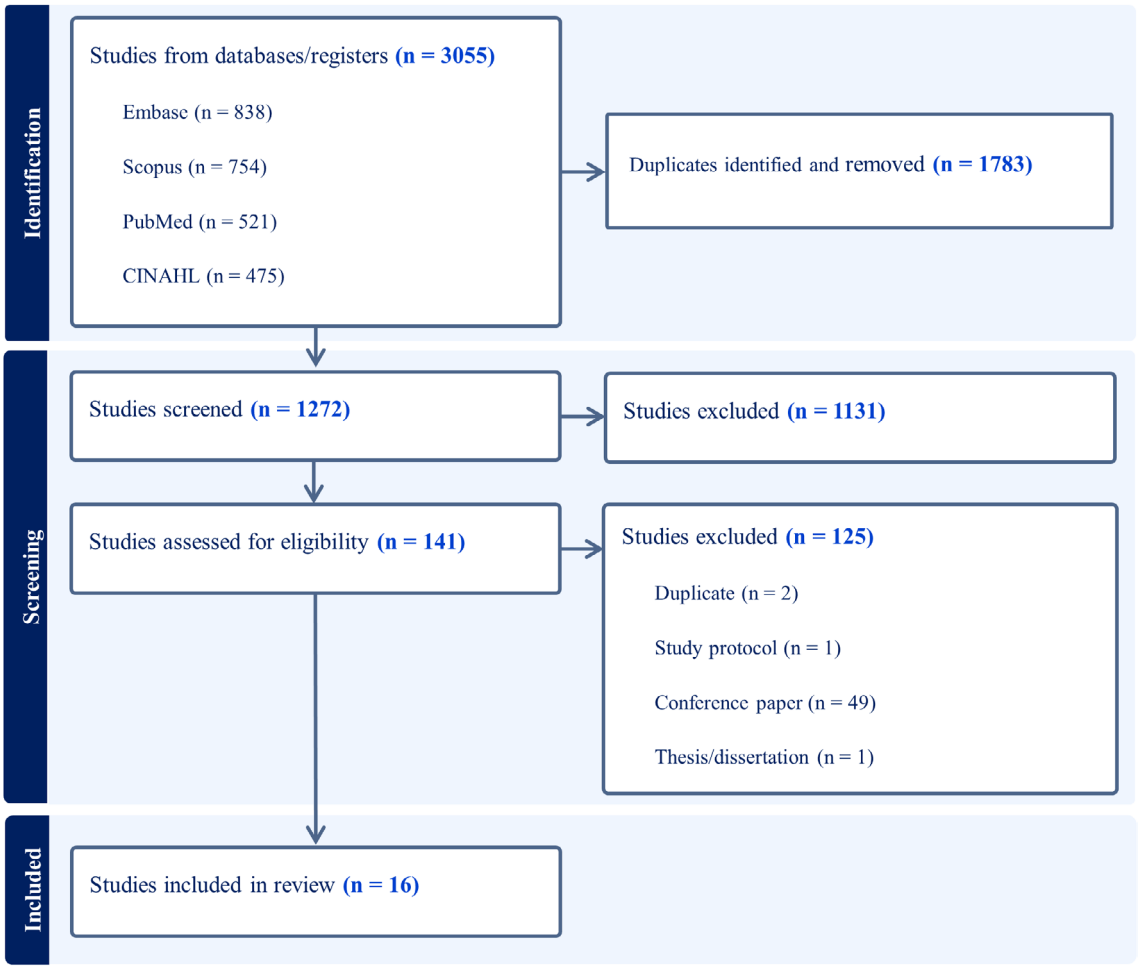

FIGURE 1 | Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) flowchart of included studies.

As shown in Table 1, most studies provided insight into nurses/midwives' or peer workers' perceptions and experiences of collaboration, with some presenting both perspectives within the same study and others presenting one side. Several studies explored service user's perspectives of receiving services from peer workers and nurses/midwives within healthcare settings. In terms of quality appraisal, most studies rated highly; however, the majority of qualitative studies used descriptive designs and while the thematic analyses were carefully carried out, they were not underpinned by a theoretical perspective or framework. Two qualitative studies used participatory action research (Winder et al. 2004) and one used Rogers' (2003) Diffusions of Innovation Theory (Rossman et al. 2012). Only one study described the theoretical perspective that underpinned the development of a shared peer worker and nursing intervention, which was Self-Determining Theory (Bergin et al. 2016).

3.2 | Summary of Key Themes

Table 2 summarises the themes identified through the narrative synthesis, including two themes related to the strengths of collaboration and five related to the tensions identified.

3.3 | Strengths of Peer Worker and Nurse/Midwife Collaborations

All studies promoted the strengths of peer worker and nurse/midwifery collaborations. These are captured in the following two themes: *valuing diverse expertise* and *enhancing care*.

3.4 | Valuing Diverse Expertise

Nine of the included studies discussed the value of diverse forms of expertise in nurse/midwifery-peer worker collaborations (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Enriquez et al. 2013; Ferville et al. 2023; Huntingdon et al. 2016; Mill et al. 2012; Munns and Walker 2015; Munns and Walker 2023; O'Dell et al. 2019; Rossman et al. 2012; Winder et al. 2004). Oncology nurses perceived that peer workers had a clearer understanding of the whole cancer journey than they did, because nursing roles tended to focus on a specific treatment modality, with one stating "the [peers] have been through it, they have experienced each stage of the disease, so they may be better equipped to answer patients' questions than I am" (Ferville et al. 2023). When providing care for *"street-involved"* women',

TABLE 1 | Characteristics of included studies.

Citation/ date	Country	Study Aim	Study type	Participants	Healthcare setting	Peer worker role	Nursing/ midwifery role	Service user population served	Description of collaboration	Key themes
Bergin et al. (2016)	Australia	Describe the development of an evidence-based, complex, nurse-led psychoeducational intervention with peer support	Descriptive evaluation using surveys, face-to-face and phone semi-structured interviews and diary entries	Nurse ($n=1$), peer volunteers (3) and service users ($n=15$)	Radiation therapy department in public hospital	Peer worker volunteers with lived experience of gynaecological cancer and radiation therapy.	Nurse with gynaecology/ oncology experience.	Women/ people with gynaecological cancer	Formalised intervention to support women consisting of three face-to-face sessions with nurse interspersed with five peer support phone calls	Peer recruitment and training, client assessment and education, Structured role definition, care protocols, supporting self-management, power dynamics, service user benefits
Cleary, Raeburn, West, et al. (2018) Paper 1	Australia	Explore mental health nurse views on nursing and peer support worker roles to facilitate consumer's involvement in decision-making.	Qualitative semi-structured interviews, thematic analysis	Mental health registered nurses ($n=9$)	Mental health care settings	Peer workers with lived experience of mental health challenges	Mental health nurses	People with lived experience of mental health challenges	Nurses and peer worker roles in facilitating decision making for service users with mental health conditions.	Peers as role models, value of lived experience, role boundaries, healthcare teams, time with service users, service user benefits
Cleary, Raeburn, Escott, et al. (2018) Paper 2	Australia	Explore challenges faced and strategies used by peer support workers when involving mental health consumers in care decisions.	Qualitative semi-structured interviews, thematic analysis	Mental health peer workers ($n=6$)	Psychiatric hospitals and community mental health services	Peer workers with lived experience of mental health challenges	Mental health nurses	Service users living with mental health conditions	Peer workers and nursing roles in facilitating decision making for service users with mental health conditions.	Peers as role models, role delineation, value of lived experience, therapeutic use of self, time with service users, service user benefits, trust and rapport

(Continues)

TABLE 1 | (Continued)

Citation/ date	Country	Study Aim	Study type	Participants	Healthcare setting	Peer worker role	Nursing/ midwifery role	Service user population served	Description of collaboration	Key themes
Cramer et al. (2017)	Australia (Urban and regional Victoria)	Describe the Supporting Breastfeeding In Local Communities (SILC) program including experiences of maternal and child health nurses in establishing and maintaining the centres	Three-arm cluster randomised controlled trial including surveys, focus groups, logbooks and visitors' comment books	Maternal child health nurses/ midwives ($n=7$)	Community based infant feeding support drop-in centres	Peer worker volunteers with lived experience of infant feeding (breastfeeding) who received training in peer counselling	Maternal and child health nurses and midwives	Women/ people in early postpartum period	Peer volunteers working alongside nurses in community settings to support infant feeding for new mothers/ parents	Implementation challenges, peer volunteer recruitment and retention, service user attendance, role satisfaction, service user and community benefits
Curtis et al. (2007)	United Kingdom (Doncaster)	To explore elements of the peer-professional interface within one breastfeeding peer support project and explore how peer supporters and health professionals Negotiate support provision for breastfeeding mothers.	Descriptive qualitative study using focus groups, thematic analysis	Volunteer peer supporters ($n=7$) community midwives and health visitors ($n=9$)	Community-based breastfeeding support during clinics, Antenatal and postnatal Sessions or hospital wards	Peer worker volunteers with lived experience of infant feeding (breastfeeding) who received training from tutor alongside a midwife academic and liaison midwives	Midwives and health visitors	Women/ people in early postpartum period	Peer volunteers working alongside midwives and health visitors in community and hospital settings to support infant feeding for new mothers/ parents	Role boundaries, peer recruitment and training, workloads, benefits for nurses and volunteers, gatekeeping, constraints on enabling working relationships

(Continues)

TABLE 1 | (Continued)

Citation/ date	Country	Study Aim	Study type	Participants	Healthcare setting	Peer worker role	Nursing/ midwifery role	Service user population served	Description of collaboration	Key themes
Enriquez et al. (2013)	USA (Chicago, Kansas City, Springfield)	To examine the role of experienced HIV peer workers who work as educators in medical Care settings.	Narrative descriptive study, semi-structured interviews via phone or face-to-face with content analysis	People living with HIV working as lay peer educators in clinical settings ($n = 15$)	HIV medical settings (e.g., hospitals, clinics)	Peer worker volunteers living with HIV	Registered nurses working in HIV clinical settings	People diagnosed with HIV	Peer educators support HIV treatment uptake and adherence, reduce stigma, and act as a liaison between service users and clinicians	Scope of peer role, motivations for role, service user connections, service user empowerment, stigma reduction, treatment support, role-modelling professionalisation
Ferville et al. (2023)	Canada (Quebec)	To explore the perceptions of accompanying patients and oncology nurses regarding The integration of peer roles into clinical teams and during the care of patients affected by cancer.	Exploratory qualitative study using semi-structured interviews and iterative analysis	Oncology nurses ($n = 6$) and accompanying patients ($n = 6$)	Oncology departments in health facilities	Peer workers with lived experience of cancer	Registered nurses with specialist oncology experience	People undergoing cancer treatment	Peer workers who accompany patients and facilitate patient care and are integrated alongside nurses into clinical teams within specialist cancer services.	Challenges of integration within teams, role understandings, lack of recognition of peer roles, maintaining connection between peer workers and nurses, benefits for nursing workloads.

(Continues)

TABLE 1 | (Continued)

Citation/ date	Country	Study Aim	Study type	Participants	Healthcare setting	Peer worker role	Nursing/ midwifery role	Service user population served	Description of collaboration	Key themes
Foster et al. (2020)	Australia	To explore nursing students' experience of traditional mental health clinical placement and How it influenced their practice and understandings of recovery from mental illness.	Interpretive qualitative enquiry using focus groups	Nursing students on placement in mental health setting ($n = 31$)	Large metropolitan mental health service	Peer support workers with lived experience of mental health challenges	Registered nurses in mental health settings	Service users living with mental health conditions	Nursing students working alongside peer workers and registered nurses while on clinical placement.	Peer worker role in humanising people with mental illness, role modelling, stigma reduction, shifting perspectives on recovery.
Hunting-don et al. (2016)	Australia	To explore how peer support providers with experience of cancer diagnosis and treatment understand and construct meaning around their experience of providing peer support.	Qualitative interviews with thematic analysis and constructivist epistemology. Part of randomised controlled trial	Peer support workers ($n = 11$)	3 x inner city public hospitals with specialist oncology facilities	Peer workers with lived experience of gynaecological cancer diagnosis and treatment	Registered nurses with specialist oncology experience	Women/people undergoing treatment for gynaecological cancer	Nurses and peer support workers partner to deliver a structured psychosocial care intervention involving face-to-face visits and phone follow up.	Role delineation, supportive care, protocol/ structured intervention, checklists and guidelines, taboo or sensitive topics, peer volunteer recruitment.
Mill et al. (2012)	Canada (Edmonton)	To evaluate the successes and elements requiring modification for the peer-based Women in Shadows outreach program.	Qualitative interviews with inductive analysis	Program staff including peer support workers and other health professionals ($n = 7$) Program service users ($n = 12$)	Harm reduction outreach program for pregnant and street-involved women in inner-city	Aboriginal peer workers with lived experience of pregnancy and street-involvement	Registered nurses working in STI and needle exchange service.	Street involved women/ people defined as currently experiencing homelessness, substance use or sex work.	Nurses and peer workers deliver an outreach service for pregnant street-involved women.	Building relationships, access to care, stress and overwhelm, role modelling, interagency interaction and coordination

(Continues)

TABLE 1 | (Continued)

Citation/ date	Country	Study Aim	Study type	Participants	Healthcare setting	Peer worker role	Nursing/ midwifery role	Service user population served	Description of collaboration	Key themes
Munns & Walker (2015) Paper 1	Australia (Kimberly region, Western Australia)	To evaluate the enhanced role of the child health nurse facilitating development of peer support for Aboriginal parents with young children in a remote setting.	Participatory action research using qualitative interviews and notes from the program facilitator's reflective diary	Peer support workers ($n=8$) Health and welfare professionals from community support agencies ($n=5$)	Outreach and home visits for Aboriginal families in remote area	Aboriginal peer workers who are well connected with the community and have experience of raising children	Community child health nurse	Aboriginal families with young children living in remote communities	Peer support workers provide liaison between child health nurse and local Aboriginal families	Community liaison, relationship building, trust and rapport, role modelling, cultural safety, parenting support.
Munns and Walker (2023) Paper 2	Australia (Western Australia)	To investigate the suitability, feasibility and acceptability of parent support, informing a culturally safe model for a peer-led support program for Aboriginal families	Participatory action research	Nurse researcher ($n=1$) Peer support workers ($n=4$) Community agency staff ($n=5$) Mothers ($n=2$)	Community Mothers Program' of outreach and home visits for Aboriginal families	Aboriginal peer workers who are well connected with the community and have experience of raising children	Community child health	Aboriginal families facing challenges with parenting.	Peer-led support for families through home visits to encourage parent empowerment and help parents positively manage the development and wellbeing of their children	Colonisation, racism, and social determinants of health, parenting support

(Continues)

TABLE 1 | (Continued)

Citation/ date	Country	Study Aim	Study type	Participants	Healthcare setting	Peer worker role	Nursing/ midwifery role	Service user population served	Description of collaboration	Key themes
O'Dell et al. (2019)	United Kingdom	To explore peer support and whether it can have an effective role in a multidisciplinary team approach to supporting a patient with a spinal cord injury.	Independent evaluation involving an online survey with descriptive statistical analysis. Qualitative focus group and telephone interviews analysed using constant comparison.	Survey ($n = 69$) and phone interviews ($n = 13$): People with a spinal cord injury, family and friends. Focus group: Peer support officers ($n = 7$), healthcare practitioners ($n = 11$)	Specialist spinal injury units, district general hospitals, nursing homes and service users' homes throughout UK.	Peer workers described as 'living well' with a spinal cord injury.	Nurses across any setting providing care for people living with spinal injuries	People adjusting to and living with a spinal cord injury	Peers are trained and employed by a national charity, the Spinal Injuries Association UK to provide outreach support across various settings including hospitals and nursing homes where nurses work.	Treatment support, taboo or sensitive topics, role-modelling, reducing isolation, timing of support, being ready to talk.
Rossman et al. (2012)	USA (Midwest)	To gain insight into the experiences and perceptions of healthcare professionals who work with peer counsellors in the Neonatal Intensive Care Unit (NICU)	Qualitative descriptive study using semi-structured interviews	Nurses, neonatologists, lactation consultants and dieticians ($n = 17$)	57 bed specialist NICU at a metropolitan medical centre in Midwestern USA.	Peer counsellors with lived experience of infant feeding (breastfeeding) their own infants in the NICU	Nurses and nurse-lactation consultants working in the NICU providing care for sick and premature neonates	Breastfeeding mothers/ lactating parents of infants being cared for in the NICU	Certified peer counsellors employed in paid positions by the NICU who have specialised NICU lactation training and skills. Some are certified lactation consultants.	Enhanced care, trust and rapport, time spent with service users, emotional support, integrated roles, communication, healthcare culture, championing the program.

(Continues)

TABLE 1 | (Continued)

Citation/ date	Country	Study Aim	Study type	Participants	Healthcare setting	Peer worker role	Nursing/ midwifery role	Service user population served	Description of collaboration	Key themes
Smeulders et al. (2007)	Netherlands (Maastricht)	To explore the Feasibility and possible benefits of a structured nurse- and peer-led self-management programme Among implantable cardioverter defibrillator (ICD) patients.	Feasibility study with pre-test/post-test design. Descriptive statistical analysis	ICD patients ($n=10$)	A university teaching hospital in	Peer workers living with cardiovascular disease who received training on the chronic disease self-management program	Cardiac nurse specialists who received training on the chronic disease self-management program	People living with cardiovascular disease with a recently implanted cardioverter defibrillator.	Peers and nurses team up to deliver a six-week structured chronic disease self-management program	Structured protocols, patient attendance and adherence, relevance of self-management support sessions, program benefits
Winder et al. 2004	USA	To explore the interaction Between the advanced practice nurse the peer advisor who provide support for unpartnered elders after Myocardial infarction (MI) or coronary artery bypass grafting (CABG).	Narrative analysis of thirty completed nursing contact logs, each representing one nurse/ peer/ Patient triad	Recovering cardiac Patients recruited from tertiary hospitals after An acute MI or CABG ($n=30$) Peers ($n=20$) Advanced practice nurses ($n=4$)	Tertiary hospitals providing specialist cardiac services	Peer advisors who have experienced either MI or a CABG and successfully completed cardiac rehabilitation.	Masters prepared nurses with clinical expertise in cardiology	Unpartnered elders (> 65 years old) recovering following hospitalisation for MI or CABG	Structured nursing and peer support program "Improving Health Outcomes in Unpartnered Cardiac Elders"	Establishing the peer role, connection and communication, rapport, peer matching.

TABLE 2 | Themes identified.

Strengths of peer worker and nurse/midwife collaborations	
Valuing diverse expertise	Working alongside people with different experiences and skillsets (Enriquez et al. 2013; Ferville et al. 2023; Mill et al. 2012), relational work (Cleary, Raeburn, West, et al. 2018; O'Dell et al. 2019; Rossman et al. 2012), addressing stigma, dispelling myths (Cleary, Raeburn, Escott, et al. 2018; Enriquez et al. 2013), clinical care and emotional support (Huntingdon et al. 2016; O'Dell et al. 2019; Winder et al. 2004)
Enhancing Care	Improved service user experience (Bergin et al. 2016; Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018), culturally safe care, respectful communication (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Munns and Walker 2015; Munns and Walker 2023), knowledge sharing, comprehensive support, facilitating service linkage (Curtis et al. 2007; Enriquez et al. 2013; Foster et al. 2020; Rossman et al. 2012; Winder et al. 2004)
Tensions of peer worker and nurse/midwife collaborations	
Clinical protocols	Focus on clinical interventions and outcomes did not encompass core of peer work, impeding development of authentic connection (Bergin et al. 2016; Huntingdon et al. 2016; Smeulders et al. 2007)
Differing priorities	Clinical assessments and interventions privileged over building therapeutic relationship when prioritising care (Bergin et al. 2016; Cleary, Raeburn, Escott, et al. 2018; Ferville et al. 2023; Smeulders et al. 2007; Winder et al. 2004)
Hierarchy, dominance and control	Peer workers positioned as helping nurses/midwives (Cleary, Raeburn, Escott, et al. 2018; Cramer et al. 2017; Curtis et al. 2007; Rossman et al. 2012; Winder et al. 2004), nurses/midwives recruiting, training and matching peer workers with service users (Bergin et al. 2016; Huntingdon et al. 2016; O'Dell et al. 2019; Smeulders et al. 2007; Winder et al. 2004)
Scope of practice and role boundaries	Uncertainty among nurses/midwives and peers about peer work scope (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Rossman et al. 2012), blur between clinical care and peer support conversations (Huntingdon et al. 2016; O'Dell et al. 2019)
Notions of peer worker success	Expectations for peer workers to role model and embody treatment 'success' with focus on symptom cessation (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Enriquez et al. 2013; Foster et al. 2020; O'Dell et al. 2019)
Close strangers	Lack of meaningful opportunities to develop understanding of each other as people, and as disciplines (Bergin et al. 2016; Cleary, Raeburn, Escott, et al. 2018; Ferville et al. 2023; O'Dell et al. 2019; Rossman et al. 2012; Smeulders et al. 2007)

peer workers and nurses recognised how their differing expertise contributed to their shared role in redressing power imbalances for marginalised people, as well as harm reduction and outreach (Mill et al. 2012). Nurses perceived that peer workers were expert in guiding people living with HIV through the stigma and social challenges associated with HIV diagnosis (Enriquez et al. 2013). Peer workers in HIV and mental health settings also valued their own expertise in stigma reduction. They indicated that their sharing their own lived experience of stigma helped ensure service users did not feel alone and provided opportunities to teach ways to reduce stigma by dispelling myths (Cleary, Raeburn, Escott, et al. 2018; Enriquez et al. 2013).

Multiple studies specifically recognised peer workers' expertise in relational work, which was perceived as promoting understanding and connection with service users (Cleary, Raeburn, West, et al. 2018; Enriquez et al. 2013; O'Dell et al. 2019; Rossman et al. 2012, 2; Winder et al. 2004). Many nurses/midwives recognised that rapport building, and empathetic sharing of ideas were important facets of peer work (Cleary, Raeburn, West, et al. 2018; Enriquez et al. 2013). NICU nurses observed breast/chest feeding peer counsellors conveying compassion for new mothers/parents, acknowledging that shared personal experience meant they "knew how to talk with these parents", which was *"priceless"* (Rossman et al. 2012, 2). Nurses working alongside peer workers with a spinal injury regarded them as delivering "*credible advice*" that helped service users adjust to the lifestyle changes imposed by paralysis (O'Dell et al. 2019). Cleary, Raeburn, Escott, et al. (2018) examined the varied views held by mental health nurses of peer worker roles, specifically in supporting service user decision making.

Some nurses/midwives recognised that discussing lived experience was a valuable way to engage with service users and build rapport, which provided the foundations for support and advocacy. Service users also recognised the value of peer workers' relational expertise. For example, in a study involving unpartnered older adults recovering from cardiac surgery, service users described relying on nurses to guide them on the physiological manifestations of health and recovery, whereas they regarded peer workers as providing friendship and emotional support (Winder et al. 2004).

3.5 | Enhancing Care

Connected but distinct to the strength of 'Valuing diverse experience' was the theme of 'Enhancing care.' The theme of enhancing care describes how the diverse experience (illustrated in the first theme) results in an improved services user experience. Nine of the included studies highlighted ways that peer worker and nurse/midwifery collaboration enhanced care (Bergin et al. 2016; Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Curtis et al. 2007; Enriquez et al. 2013; Ferville et al. 2023; Foster et al. 2020; Munns and Walker 2015; Munns and Walker 2023; Rossman et al. 2012; Winder et al. 2004). For example, one study explored the perspectives of Aboriginal peer workers and a child health nurse, who partnered to implement culturally safe responses addressing health disparities for remote Australian Aboriginal families (Munns and Walker 2015, 2023). The identified benefits of working together included, improved culturally respectful communication, reciprocal knowledge sharing, reflexivity and increased self-determination of the community served (Munns and Walker 2015, 2023). Different kinds of care enhancement were noted across contexts, including peer workers' facilitating service linkage for service users with cancer and HIV (Bergin et al. 2016; Enriquez et al. 2013); nurses and peer workers developing collaborative care plans with service users with cardiovascular disease (Winder et al. 2004); peer workers in the NICU, and community settings, providing comprehensive infant feeding support alongside NICU nurses, midwives and health visitors (Curtis et al. 2007; Rossman et al. 2012); and peer workers' in mental health settings supporting reflexive practice among nurses and other clinicians to help temper negative language and discourse around people living with mental health challenges (Cleary, Raeburn, Escott, et al. 2018). In the context of busy healthcare settings, the time that peer workers could spend with service users was also highly valued by nurses/midwives and perceived to benefit not only them, but the whole team (Enriquez et al. 2013; Foster et al. 2020; Rossman et al. 2012; Winder et al. 2004). As one nurse in the NICU recognised, "It's not like a nurse who has three patients. When that [infant feeding] peer counsellor is working with that mother, that's the only person around. They're very focused" (Rossman et al. 2012).

3.6 | Tensions of Peer Worker and Nurse/Midwife Collaborations

Studies also raised tensions arising in peer worker and nurses/midwives' collaborations within healthcare environments. These are captured in the following six themes: *Clinical protocols; differing priorities; hierarchy, dominance and control; scope of practice and role boundaries; notions of peer worker success*, and *close strangers*.

3.7 | Clinical Protocols

Six studies discussed peer worker and nurse/midwifery collaborations that used protocols to standardise and delineate roles. For example, Bergin et al. (2016) used a collaborative model of structured nurse and peer worker interventions to support women/people with gynaecological cancer (Bergin et al. 2016). In this psychoeducational intervention study, nurses used a pre-prepared and evidence-based checklist to determine service users' top three issues and, based on the results of the checklist, created a care plan for nurses and peer workers to follow (Bergin et al. 2016). Similarly, Smeulders et al. (2007) initiated a coordinated series of self-management interventions for people with implantable cardiac defibrillators (Smeulders et al. 2007). These types of standardised protocols were perceived as a means of ensuring consistent delivery of support interventions and systematic measurement of their impact on service user needs and outcomes (Bergin et al. 2016; Huntingdon et al. 2016). Application of protocols instilled confidence among peer workers and nurses that all necessary aspects of care would be covered, including clinical and supportive aspects, education and coaching (Bergin et al. 2016).

Despite these perceived benefits, across several studies, peer workers indicated that protocols often focused primarily on clinical interventions and outcomes, and did not encompass the core of peer work, viewed as connecting with individual service users and understanding their unique needs and priorities (Bergin et al. 2016; Cleary, Raeburn, Escott, et al. 2018; Huntingdon et al. 2016). As an example, peer workers in cancer care experienced structured checklists and protocols as impeding their development of an authentic connection and collaboration with service users (Huntingdon et al. 2016). As such, peer workers dismissed these protocols as 'just a list' and reported instead focusing on 'what they [the service user] want to talk about' (Huntingdon et al. 2016, 852). These findings suggest that protocols may reflect the priorities of clinicians and health services and thus may not reflect meaningful integration of peer work.

3.8 | Differing Priorities

Five studies illustrated that irrespective of the presence of formal protocols, nurses/midwives focus on clinical interventions and outcomes contrasted with peer workers' priority of relationship building and connection with service users. Specifically, peer workers reported that clinical interventions and outcomes were valued and prioritised over their task of relationship building, which could result in tensions. For example, peer workers in cardiac rehabilitation described nursing staff expecting them to discuss exercise with service users, a task peer workers viewed as being clinical in nature. In contrast, peer workers in this instance believed their focus should be *'talking'*, and being a *'sounding board'*, or the *'problem solvers'* and *'cheerleaders'* for service users (Winder et al. 2004, 88). Similarly, peer workers in mental health settings indicated that services and clinicians

privileged clinical assessments and interventions over peer work. In contrast peer workers believed that a focus on relationship building, which could involve watching television together or chatting about 'everything and nothing', was more effective than clinical approaches for building rapport and gaining a true understanding of the service user's needs and priorities (Cleary, Raeburn, Escott, et al. 2018; Ferville et al. 2023). Indeed, mental health peer workers noted that relational connection provided an alternative experience for service users to the perceived *'forced nature'* of clinical encounters (Cleary, Raeburn, Escott, et al. 2018, 1269). Peer workers frequently reported resisting clinician determined approaches to care by returning to peer practices of relational connection, tailoring support, and drawing on their own and their peer's lived experience and strengths (Bergin et al. 2016; Smeulders et al. 2007).

3.9 | Hierarchy, Dominance and Control

Several studies pointed to hierarchical structures within healthcare settings, which led nurses/midwives co-opting and controlling the work of peers, rather than collaborating with them. Additionally, nurses could position peer workers as 'helping' nurses or easing their workloads, as opposed to perceiving peer work as an independent discipline offering unique therapeutic benefits for service users. In a study of infant feeding peer support workers, some nurses/midwives described *"using"* peer workers for certain tasks *or* "*pulling them in*" to conversations to meet their own objectives (Curtis et al. 2007). As one nurse stated, "you've got someone there who can help you with your workload should you have somebody who needs to be supported and you haven't got the time to give them" (Curtis et al. 2007). Hierarchical structures were revealed when NICU nurses, who perceived they were unable to spend sufficient time with the mothers/parents of the babies in their care, described peer counsellors as a *"blessing"* with one stating "the peer counsellors are responsive when I need them to be at the bedside, they are always receptive to assisting us" (Rossman et al. 2012, 6). Similarly, nurses working in community cardiac rehabilitation remarked on their appreciation for having another set of "eyes and ears" to guide their own interventions, suggesting some nurses may be more comfortable with the notion of peer workers working for them, rather than alongside them (Winder et al. 2004, 188).

Peer workers could also perceive nurses *as "territorial"* or *"gatekeepers"* who controlled their access to service users and were hesitant to "relinquish the power" (Curtis et al. 2007). A study involving peer workers and midwives supporting young mothers and parents who were breast/chest feeding revealed that "*debriefing"* sessions were an opportunity for midwives to control peer practice and maintain surveillance over their interactions with service users (Cramer et al. 2017). Issues of control were also reflected in a mental health setting, where peer workers noted that they felt *"micro-managed"* by nurses, as though they were a contractor or not valued and viewed as a colleague and rather viewed as a patient (Cleary, Raeburn, Escott, et al. 2018).

Peer workers also experienced nursing/midwife control of service user matching. Peer worker and service user matching can be important for connection. For example, in the spinal injury setting, some service users preferred to see a peer worker of the same gender to support the ability to find points of connection and discuss sensitive topics (O'Dell et al. 2019). However, service user matching was frequently controlled by nurses/midwives, with little regard for service user or peer worker requirements. Several studies discussed how nurses were tasked with recruiting and matching peer workers with service users and overseeing their initial contact with each other (Bergin et al. 2016; O'Dell et al. 2019; Winder et al. 2004). In one study, oncology nurses recruited peer workers and matched them with service users based on their perceptions of each party's medical and social circumstances, with possibly little regard for whether this would facilitate peer connection (Huntingdon et al. 2016). In another study, cardiac nurses screened service users during a home visit and planned each peer worker intervention based on their assessment of service user priorities, orchestrating the match based on service users age, gender, and personality (Winder et al. 2004). Despite nurses' good intentions and efforts to match people appropriately, these types of circumstances revealed the clear position of power that nurses/midwives can hold in relation to recruiting peer workers based on clinician-focused objectives that may not always align with the ethos of peer work (Bergin et al. 2016; Smeulders et al. 2007).

Conversely, nurses/midwives could experience these engagements with peer workers as burdensome. For example, two studies highlighted how nurses/midwives perceived themselves as poorly recognised and remunerated for the many hours they spent recruiting and training peer workers and described feeling disheartened and frustrated at high attrition rates despite their efforts (Cramer et al. 2017; Winder et al. 2004). However, it is unclear whether these nurses/midwives questioned the appropriateness of their recruiting, training and ongoing management of peer workers.

3.10 | Scope of Practice and Role Boundaries

Several studies discussed challenges for peer workers and nurses/midwives in navigating scope of practice and professional role boundaries. Cleary, Raeburn, Escott, et al. (2018) give examples of where mental health nurses expressed concern about peer workers' professional boundaries. In particular, this related to when the focus of interactions shifted onto the peer workers' personal story, which was perceived as creating undue influence or steering the service user away from a clinical intervention perceived as ideal by the nurse (Cleary, Raeburn, West, et al. 2018).

Tensions also arose when the scope of peer work appeared to be poorly understood by peer workers themselves (Cleary, Raeburn, Escott, et al. 2018). For example, although giving advice is generally not considered part of peer work scope of practice, mental health nurses reported that peer workers sometimes overstepped this scope and offered medical advice to service users (Cleary, Raeburn, West, et al. 2018). Similarly, lactation consultants in the NICU expressed concerns when enthusiastic peer workers "crossed a line" and needed reminding to "stay within scope... so that they could never be accused of giving the wrong advice to a mother" (Rossman et al. 2012, 9). As one NICU nurse noted;

"It's really hard when you've now had this idea put into a mom's head [by a peer worker] that they can hold their baby, but I

know that they're (baby) very, very sick. Now, I have to be the bad guy who is like, Actually, no. You can't hold your kid today" (Rossman et al. 2012).

However, Rossman et al. (2012) described how tensions around scope of practice also involved an element of territoriality among nurses, who could resent peer workers when it was perceived that service users placed greater value on the peer worker's support. For example, family members who "s*pecifically sought the advice and support of the peer counsellor instead of the designated healthcare team member"*(Rossman et al. 2012).

Peer workers could also experience tensions around nursing/midwifery scope of practice. These centred on who was responsible for (or willing to undertake) conversations with service users about uncomfortable or taboo topics. Peer workers in the spinal injury setting expressed the view that nurses tended to align their scope of practice more with injury care, therefore shifting difficult conversations with service users about issues such as sexual dysfunction and incontinence to the peer workers (O'Dell et al. 2019). In the gynaecological cancer setting, peer workers indicated that they were frequently called on to tackle the topic of vaginal dilation after radiotherapy—noting that they themselves had experienced the long-term benefits of understanding this (Huntingdon et al. 2016). However, some peer workers felt unsupported by nurses/midwives, and awkward raising these topics with service users, and could even follow the nurses' lead in avoiding the topic, with one stating "If the nurse doesn't cover it, then I don't worry about covering it" (Huntingdon et al. 2016, 854). These findings expose a potential risk for important conversations to be missed when neither peer workers or nurses feel comfortable broaching a topic, and there is a blur between clinical care and peer support conversations.

3.11 | Notions of Peer Worker Success

Several studies revealed tensions around nurses/midwives' expectations for peer workers to role model and embody treatment *'success'* (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Enriquez et al. 2013; O'Dell et al. 2019). Peer workers could be held up as the ideal 'patient' by nurses, who perceived peer workers as having managed their health issue and made a meaningful contribution to health services (Cleary, Raeburn, West, et al. 2018; Enriquez et al. 2013; O'Dell et al. 2019). Peer workers could find themselves positioned as embodying hope for people with lived experience of mental health challenges, spinal injury, or cancer, which failed to capture the purpose of peer work (Cleary, Raeburn, Escott, et al. 2018; Cleary, Raeburn, West, et al. 2018; Huntingdon et al. 2016; O'Dell et al. 2019). For example, in a study of mental health services, nursing students perceived that peer workers provided service users hope for clinical recovery (Foster et al. 2020). Acknowledging that students are still learning, this indicates that mental health peer workers' emphasis on personal recovery has been overlooked, including the focus on living a meaningful life with or without mental health challenges, rather than on cessation of mental health symptoms. Indeed, nurses focus on symptom cessation rather than living with a health issue meant that they could insist that peer workers on the team ought to be at the 'right' stage of recovery so as not to trigger service users (Cleary, Raeburn, West, et al. 2018).

One study of nursing perspectives in HIV setting, which was conducted by nurse researchers, identified a theme labelled "Attributes of a successful peer" and identified 'successful' attributes such as "living with HIV for a long time, socially active, adherent to their HIV treatment and able to maintain a professional relationship" (Enriquez et al. 2013). However, it is uncertain whether HIV peer workers would share these ideas of 'success'. In other studies, peer workers emphasised that a health condition—be it HIV, cancer, spinal injury or mental distress—was just one aspect of a person's experience, and stressed the importance of knowing that their lives had continued despite these conditions, albeit challenging at times (Enriquez et al. 2013; Huntingdon et al. 2016; O'Dell et al. 2019).

3.12 | Close Strangers

Lack of rapport between peer workers and nurses/midwives was an additional barrier to collaboration. Peer workers in mental health settings felt that getting to know service users was easy, yet establishing a strong working relationship with clinicians was often difficult and could take years, if it happened at all (Cleary, Raeburn, Escott, et al. 2018). For example, volunteer peer workers in an oncology setting did not feel they were viewed as members of the multi-disciplinary team, described by one as being "in the computing cloud, fluttering around the team" (Ferville et al. 2023, 3). Nurses echoed this perception, acknowledging they "didn't really know the peers [they] were working alongside" (Ferville et al. 2023) and building effective strategies to promote collaboration took time, which some simply did not have (Cleary, Raeburn, West, et al. 2018). Only one study described efforts to build connection, describing a weekly luncheon for breast/chest feeding peer workers and nurses in the NICU, which allowed nurses and peer workers to meet informally and foster mutual understanding and trust (Rossman et al. 2012). Some studies described how peer workers and nurses connected during educational activities or to discuss individual service user care (Bergin et al. 2016; O'Dell et al. 2019; Smeulders et al. 2007). Additionally, one paper suggested the inclusion of peer workers in staff meetings could improve their integration, indicating the degree to which peer workers can be excluded from healthcare teams (Ferville et al. 2023). Collectively, the studies expose a lack of meaningful opportunities to strengthen the working relationship between peer workers and nurses/midwives. Indeed, some peer workers perceived that mental health nurses regarded their presence as tokenistic—for the purpose of demonstrating lived experience engagement—as opposed to truly valuing peer workers in the multi-disciplinary team (Cleary, Raeburn, Escott, et al. 2018).

4 | Discussion

This scoping review and narrative synthesis provide the first comprehensive review of peer worker and nurse/midwife collaboration in frontline health services. While this review indicates that peer workers and nurses/midwives can acknowledge and value each other's expertise and appreciate how their combined strengths enhance service delivery, studies exposed tensions in peer worker and nurse/midwife collaborations, including in

relation to clinical protocols, organisational hierarchies, scope of practice and roles, and notions of successful peer work.

Multidisciplinary teamwork hinges on the capacity of team members to recognise, reflect on, and share power (Stevens et al. 2021). However, findings from this review indicate that within institutional hierarchies, nurses and midwives could control, rather than collaborate with peer workers. Peer workers, whose focus was primarily on relational connection and mutual support for service users, could find their roles co-opted by nurses/midwives for clinical interventions and outcomes. Standardised protocols could reinforce the priorities of clinicians and health services, rather than those of peer workers.

The privileging of medical knowledge in healthcare has been linked to clinical dominance in health services (Kemp et al. 2020), and the tendency for clinicians to co-opt peer work to clinically based tasks has been noted previously. In the mental health services context, efforts have been made to divert peer work to restrictive and medicalised practices (Beresford and Russo 2016; McWade 2016; Repper and Carter 2011). A review of peer navigator programs for people living with HIV also found that the scope of peer work practice was often limited to performing tasks such as reminders and follow-up for appointments (Krulic et al. 2022). The emerging evidence base for peer work, which frequently emphasises health outcomes and behaviours, arguably reinforces a limited and largely medicalised role for peer workers in healthcare delivery (Krulic et al. 2022). While peer workers themselves may at times focus on treatment adherence, outcomes or health behaviours if this is the priority of the service user, peer work is not contingent on this. Indeed, the intention of peer work is *not* to 'do to' or push for compliance, but to 'be with' and support the needs of the person, whatever they may be (Mead 2010, 5).

Our review findings indicate a need for clear scope of practice and role definitions to ensure that peer workers practice within scope—and do not provide medical advice—and that nurses/midwives provide clinical explanations and information on health behaviours as part of their role—including on topics that may be considered awkward, embarrassing, or taboo so they do not always fall to peer workers. However, protocols and scope of practice definitions need to occur in genuine collaboration to ensure they meet the needs of both parties. This would necessarily involve meaningful dialogue between peer workers and nurses/midwives that acknowledges power, professional hierarchies, and shared responsibilities.

Expecting peer workers to comply with clinical dominance in healthcare hierarchies, and co-opting their work for clinicians' objectives, not only undermines the intention of peer work, but is also its potential value to service users as an important alternative to clinical care (Kemp et al. 2020). It is also unlikely to be considered a sustainable or satisfying practice for peer workers (Hurley et al. 2016). Research on peer worker and clinician relationships indicates a pervasive devaluing of peer workers by clinicians, and the positioning of peer work as lower status or non-essential, which is linked to both positional and clinical power in healthcare hierarchies and stigma towards people with lived experience (Byrne 2013; Vandewalle et al. 2016).

Any discussions of stigma and power in clinical hierarchies must be carefully navigated in order that peer workers are not positioned as 'vulnerable' and the 'problem', but rather that discriminatory practices of clinicians towards peer workers are addressed (Thornicroft et al. 2007). Previous research indicates that clinicians, with the authority and status of credentialing registration bodies, may mistakenly view the expertise and intentionally informal mutuality of peer work as lacking professionalism (Vandewalle et al. 2016). Clinicians may also use stigmatising or dehumanising language or express negative views about service users that are derogatory towards peer workers who share a lived experience (Byrne et al. 2019; Vandewalle et al. 2016). Without organisational commitment to pre-empt and address these power dynamics, peer workers may remain positioned as low status or non-essential (Kemp et al. 2020).

Nurses/midwives across several of our reviewed studies held responsibility for identifying potential peer workers from within service user cohorts or supervising peer worker roles. Reflecting on nursing/midwifery agendas and the prevailing cultures that exist within healthcare settings is therefore important (Cramer et al. 2017; Winder et al. 2004). Ideally, nurses/midwives would take steps to relinquish power and support the establishment of peer worker roles to design and govern peer work activity within healthcare environments. Dialogue between peer workers and nurses/midwives, including co-development or revision of protocols for collaboration, would be optimised through leadership support. Hierarchical leadership structures within health services rarely pivot to recognise peer worker roles or validate peer worker skills. Rather, progressing up the hierarchical ladder may require peer workers to assimilate further into the clinical paradigm, and opportunities to utilise their peer work skills to advance to senior roles within mainstream healthcare services may be limited (Debyser et al. 2018). However, our review reinforces the importance of supporting the value of peer workers' relational work for connecting with, identifying and supporting service user needs (Cleary, Raeburn, West, et al. 2018; Rossman et al. 2012; Winder et al. 2004). Emphasising the value of peer work within organisational hierarchies is not only in the interests of peer workers. Research indicates that collaborative models of care that are supported by leadership teams that actively value peer work may indeed be more successful in terms of health outcomes than models of care that focus on clinical outcomes only (Byrne et al. 2018). Peer workers can facilitate nurses/midwives and multidisciplinary teams when building rapport, challenging low expectations for service users among clinicians, and planning and prioritising care (Cleary, Raeburn, Escott, et al. 2018). Further research on peer worker and nurses/midwives perceptions of genuinely peer-led models of care is needed, including evidence of the effectiveness of these models by way of service user reported experiences and outcomes (Krulic et al. 2023).

It is imperative that leadership teams afford peer workers and nurses/midwives meaningful opportunities to connect. Our findings indicate that peer workers and nurses/midwives work in close proximity, but often with little opportunity to build relationships. It is perhaps hardly surprising that when healthcare workers are disconnected in hierarchical structures, knowledge of each other's roles and scope of practice is limited and relationships become fraught (Kemp et al. 2020). However, connection,

reflection, and dialogue may not be sufficient to create genuine collaboration in entrenched clinical hierarchies. Our findings indicate that nurses and midwives can superimpose notions about successful peer work onto peer workers, often emphasising treatment adherence and clinical recovery, rather than relational connection with service users. Therefore, appropriate recruitment, training and supervision of team members, ongoing opportunities to meet for educational and social purposes, and building rapport as a team are essential ingredients for successful collaboration (Munns and Walker 2015; Rossman et al. 2012). This is the ongoing work needed to ensure peer workers and nurses/midwives are supported to work to their strengths, feel valued, and meet service user needs within the resource and workforce constraints of contemporary healthcare settings.

4.1 | Strengths and Limitations

Our scoping review focused on studies that discussed details of collaboration between peer workers and nurses/midwives from their own perspective or that of service users. While this enhances the depth of our narrative analysis to expose nuanced power dynamics and tensions, it potentially overlooks valuable insights or trends that could emerge from a broader examination of research on clinical outcomes of nurse/midwife-peer worker collaborations. Additionally, this review does not account for every setting where peer workers and nurses/midwives collaborate, and studies were excluded where nurse/midwife and peer worker involvement was present, but no analysis of the collaboration was undertaken.

5 | Conclusion

Our review indicates strengths and tensions of peer worker and nurse/midwife collaboration in contemporary healthcare settings. Successful collaboration requires attention to power dynamics within healthcare cultures and opportunities to connect and understand each other's disciplinary expertise, including strategies to optimise partnership and mobilise collective strengths to further enhance care. Equipping peer workers and nurses/midwives with the principles, tools, time, training and inclusive environments to navigate professional boundaries and evolve collaborative ways of working within healthcare settings is now required to ensure meaningful integration of peer workers and optimal care experiences, leading to better health outcomes for service users.

Author Contributions

Olivia Hollingdrake conceptualised the study and methodology, and conducted data extraction, quality appraisal, formal analysis and writing – original draft, reviewing and editing. Emma Paino conducted formal analysis and writing – reviewing and editing. Sarah Warzywoda contributed to the methodology and conducted literature searching, data extraction, formal analysis and writing, original draft. Aaron Akpu Philip conducted literature searching, quality appraisal and writing – review and editing. Judith Dean provided supervision and writing – review and editing. Chris Howard conceptualised the study, provided supervision and writing – reviewing and editing. Jo River conceptualised the methodology, provided supervision, conducted formal analysis, and writing – original draft, reviewing and editing.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data available on request due to privacy/ethical restrictions The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Peer Review

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.