THE PEER WORKFORCE REPORT

Mental health and alcohol and other drug services

WA Peer Supporters' Network. 2018. ***The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services.*** http://www.comhwa.org.au/wapsn

p: (08) 9258 8911

e: info@peersupportwa.org.au

w: comhwa.org.au/wapsn

PO Box 176 Cannington 6987

Table of Contents

Introduction

This Report provides evidence-based guidance on how to support peer workforce growth and integration within the mental health and alcohol and other drug sectors, based on results of a multi-stakeholder study conducted by the WA Peer Supporters' Network in 2017, the *Peer Workforce Study: Mental Health and Alcohol and Other Drug Services ('Peer Workforce Study')*.

The report presents the findings of the Peer Workforce Study and provides an overall picture of *demand, benefit, supply* and *sustainability* factors to inform peer workforce investment and peer development requirements. It outlines factors that drive or impede peer workforce growth and retention in Western Australia and makes industry recommendations for peer workforce growth and development.

This Report makes a unique contribution to applied peer work research through presenting multiple stakeholder perspectives on peer work. It considers the perceptions of individuals, families and carers about the peer workforce, including extent of awareness, interest, access and experiences of peer work. It explores peer workers' views about workplace factors that shape their satisfaction, wellbeing and retention in the role. It considers employers' attitudes and readiness for peer workers and identifies what they perceive as barriers and enablers of peer workforce growth for their organization.

This Report also makes a unique contribution by presenting research that is designed, led and conducted by and with peer workers.

Report Authors

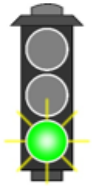
The West Australian Peer Supporters' Network (WAPSN) was established in 2014 to advance peer support and peer work roles across a range of sectors and community contexts, and to act as an interim peer workforce association. The WAPSN is a collaborative news sharing, learning and networking forum to connect people who are practicing, or aspire to practice, peer support in formal roles (peer support workers) and informal roles (peer supporters). The WAPSN also promotes and facilitates peer support and peer work voice, through advice, consultation and sector representation, and has 300 members. Auspiced by the state's mental health consumer association Consumers of Mental Health WA (CoMHWA)

with funding support of the Mental Health Commission of Western Australia, the WAPSN collaborates with consumer/individual, peer worker, carer, family and service champions to promote and advocate for peer workforce growth and development in a range of sectors.

Acknowledgments

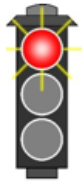
The Peer Workforce Report was made possible through funding support of the Mental Health Commission and auspicing support of Consumers of Mental Health WA. We wish to thank all people who contributed to and promoted the survey.

Summary Graphic



WORKFORCE DEMAND

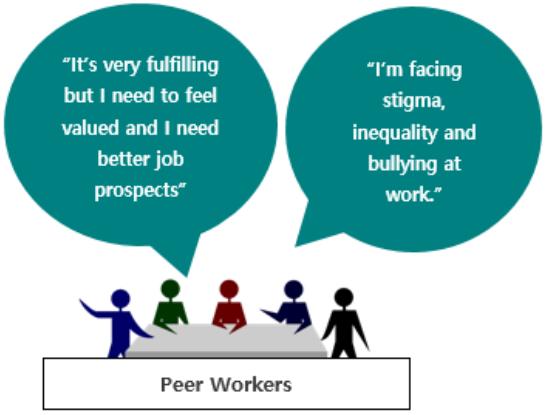
SUPPLY OF WORKERS



WORKFORCE UPTAKE
WORKFORCE SUSTAINABILITY
SYSTEM LEADERSHIP

RECOMMENDATIONS

1. SERVICE UPTAKE TO MEET LOCAL NEEDS
2. SYSTEM-WIDE GROWTH STRATEGY AND TARGETS
3. TRACKING PEER WORKFORCE GROWTH
4. AWARENESS, EDUCATION AND NAVIGATION
5. OUTCOMES EVALUATION
6. POLICY LEADERSHIP AND COMMITMENT
7. DUAL QUALIFICATIONS PATHWAYS
8. COMMISSIONING LEADERSHIP
9. OCCUPATIONAL SAFETY, REPRESENTATION AND SUPPORT



Executive Summary

The report presents the findings of the 2017 Western Australian multi-stakeholder Peer Workforce Study conducted by the WA Peer Supporters' Network. It provides an overall picture of *demand, benefit, supply* and *sustainability* factors to inform peer workforce investment and peer development requirements. It outlines factors that drive or impede peer workforce growth and retention in Western Australia and makes industry recommendations for peer workforce growth and development.

Key Findings

Peer Workforce Demand, Supply, Uptake and Barriers and Enablers for Growth

Peer Work is a desired and beneficial support option. Around 9 in 10 of individuals, families and carers surveyed reported peer support would benefit them and supported having choice of access to a peer worker in services. 83% of individuals, families and carers who had accessed a peer worker had a positive experience. Based on survey responses and industry data available, there is no evidence that the peer workforce is expanding to meet participant needs. There is a need to improve ease of access to peer workers and peer support options, and a need to grow awareness and understanding of peer work roles among individuals, families and carers. The majority of peer workers are dissatisfied with job availability and career pathways.

Services are expected to grow the peer workforce within an overall shortfall of government commitment and investment in peer roles and service managers felt that stronger government leadership and funding commitments would be helpful. To make peer work widely available across the mental health and alcohol and other drug sector, clear and ongoing government policy commitments must be signalled to the sector and strategic commissioning approaches developed to overcome contractual barriers, introduce funding streams and incentives, and to ensure capacity building mechanisms are sufficient for peer workforce supply, retention and uptake by services. Assistance for alcohol and other drug peer workers to access training options equivalent to and supporting integrated competencies with mental health peer work is also recommended.

Workforce Sustainability: Satisfaction, Retention and Wellbeing

3 in 4 peer workers were satisfied in the workplace overall and view peer work as a greatly fulfilling vocation. However, peer workers are facing job shortages, remuneration problems and poor career progression options. Peer workers are also exposed to significant psychosocial health and safety risks in the workplace. 42% were dissatisfied with levels of stigma and discrimination in the workplace, a majority had taken sick leave for work-related reasons, and 1 in 5 had resigned for work-related reasons, which strongly corresponded to peer workforce management problems, such as workplace bullying. Disturbingly frequent experiences of stigma, discrimination and bullying in the workplace require immediate attention to and improvement of peer workplaces to support peer workers' health, wellbeing and retention. Peer workers do not have the same level of occupational regulation and representation that established workforces do and there is a need for government and employers to support other mechanisms for safeguarding employment relations, described within the report recommendations.

Conclusion

This Report finds that peer work carries extensive benefits for, and demand by, individuals, families and services and yet there is no demonstrable peer workforce growth in Western Australia. There is an urgent need for strengthened policy commitments, growth targets and strategies, tied to commissioning for peer work and greater support for essential capacity building and safeguarding arrangements for peer workforce safety, equality and retention in the workplace.

Strategic, coordinated and proactive commitment is needed across all stakeholders (governments, service providers, workforce industry bodies, peer workers, and consumers and family representative and advocacy groups) to fully establish peer work as a core workforce in the mental health and alcohol and other drug sectors. Recommendations from this Report offer a suite of nine areas of action for jointly progressing the peer workforce in Western Australia, including recommendations for employers, policy makers and commissioners.

Summary of Recommendations

***Recommendations 1,2, 8 and 9 are classified as recommendations for immediate action.**

1 ***Service Uptake:** Peer workforce uptake by mental health and alcohol and other drug services.

2 ***System-Wide Strategies and Targets:** Development of system-wide peer workforce growth targets and peer workforce strategies

3 **Tracking Peer Workforce Growth:** Establishment of a mechanism for monitoring peer workforce growth across parts of the industry (e.g. Peer Work Census)

4 **Awareness, Education and Navigation:** Greater awareness raising, education and assistance to individuals, families and carers to access peer work and peer support options by services and across the system.

5 **Outcomes Evaluation:** An ongoing commitment to capturing and sharing the difference made by the peer workforce, by services and across the system.

6 **Policy Leadership and Commitment:** Inclusion of the peer workforce on an ongoing basis in strategies, policies and plans relating to mental health and/or alcohol and other drug services

7 **Dual Qualifications Pathways:** Development and resourcing of training for equal supply and uptake of peer workers across the mental health and alcohol and other drug sector

8 ***Commissioning Leadership:** Commissioning strategies to support achievement of peer workforce targets and strategies, including modifying current contacts, new funding streams, grants/capacity building and ongoing workforce support mechanisms.

9 ***Occupational Safety, Representation and Development:**

- Support and investment in peer worker occupational representation to the sector, including: collective representation, employee advice and representation, and development of standards, advice, resources and training on the peer workforce, and
- Proactive employer response to safety and inclusion issues identified through this report, through peer worker consultation and uptake of good practices

Background and Key Concepts

What is Peer Work?

The WAPSN utilises the following definitions in its work and this report.

Peer support: *"a relationship of respect, support and reciprocity between people who mutually identify a significant shared identity and/or experience".*

Peers: *people who mutually identify as having a significant shared identity and/or experience*.

Peer workers: *workers whose identity as a peer is an essential requirement of their role, including individuals, families and carers, and including people in paid and volunteering roles.*

Peer Work as a vocation is broad: it exists, and has potential to further grow, across a range of industries. Peer relationships are utilised in programs for a diverse range of communities, and including members of the LGBTIA+ community, women, men, people from specific cultural backgrounds, Aboriginal and Torres Strait Islander people, people with personal experiences of mental health challenges and/or alcohol and other drugs, youth, prisoners, people with disabilities and people with chronic health conditions. Occupations that involve significant and distinctive personal, social and situational demands have also utilised peer relationships for greater wellbeing, such as in sex work, the armed forces and frontline emergency responders (police, fire and ambulance personnel).

Peer workers draw on the knowledge and wisdom of living with and through their unique social and cultural identities and/or experiences. They may use their peer knowledge to offer support to others with similar experiences (peer support workers), and/or to enhance services in other ways (such as peer educators, peer workforce managers, peer researchers, peer consultants and representatives). Peer Workers continuously utilise peer connections, knowledge, identity and experiences as a distinct type of expertise. This contrasts with professional staff who may also have these experiences, but who are principally hired to apply other qualifications and skills in their roles[1].

The Peer Workforce Study focused on peer workers who have experience of mental health issues and/or alcohol and other drug use as individuals, families and carers. The mental health and alcohol and other

drug sectors were selected for exploring characteristics of the peer workforce as two health and community service sectors where workers have been significantly engaged in Western Australia. The remainder of this report is therefore focused on and referring to mental health and alcohol and other drug peer work when peer work is discussed, but the authors acknowledge the potential value and need for similar research in other peer workforce contexts.

The Policy Context for Peer Work

Peer workers have the potential to significantly benefit the mental health and alcohol and other drug sectors by improving recovery outcomes and cultures of service.

These benefits include:

- cost savings through optimised care[2]
- enhanced engagement in health promotion and harm reduction initiatives[3]
- improved personal outcomes, such as enhancing mental health recovery[4]
- increased hope, wellbeing, self-care and community participation[5]
- enhanced quality of life[6]
- reduced stigma and enhanced social inclusion[7]
- enhanced engagement and participation in treatment and support[8]
- reduced hospital admission[9]
- crisis prevention for those at risk of suicide[10]
- as a consumer and carer preferred strategy for preventing seclusion and restraint[11]
- enhanced recovery attitudes of staff[12]
- improved recovery-focused cultures of service[13]

The most comprehensive national study of the mental health peer workforce, conducted by Health Workforce Australia (HWA) in 2011 recommended expansion of the peer workforce, for reasons including: strengthened cultures of person-centred and recovery practice; enhanced support outcomes; reduced hospitalisation costs and contribution to overall mental health workforce sustainability[14]. Peer worker effectiveness and contribution to service outcomes is also likely to increase as growing numbers

of peer workers complete the nationally recognised Certificate IV (Mental Health Peer Work) qualification.

The Mental Health Commission's *Better Choices, Better Lives: The WA Mental Health, Alcohol and Other Drug Services Plan 2015-2025*, commits to supporting peer workforce growth. The plan identifies the need for substantial increases in the peer workforce in clinical and community support settings and commits to progressing expansion of the mental health and alcohol and other drugs peer workforce across the service spectrum by the end of 2017[15]. The 10 Year Plan includes a commitment to develop a comprehensive workforce planning and development strategy for the mental health and alcohol and other drug services that will include "key priorities and strategies to build the right number and appropriately skilled mix of staff"[16]. However, it does not specify a workforce growth target.

The National Mental Health Commission, a federal mental health advisory and reform agency, identified peer workforce growth as an immediate priority within its 2014 National Review of Mental Health Programmes and Services and announced a ten year commitment to progressing peer workforce growth[17]. The Commonwealth Government's current 5th National Mental Health and Suicide Prevention Plan identifies peer work as a priority area for improving mental health system performance. The Plan describes peer workers as "sporadically utilised and poorly supported" despite their important role in recovery-oriented services, provide meaningful support and model positive outcomes[18]. It includes a commitment to development of National Mental Health Peer Workforce Development Guidelines and the inclusion of a national performance indicator on peer workforce growth in clinical mental health services, but does not include any growth targets or specific mechanisms for stimulating peer workforce growth[19].

The National Alcohol and Other Drug Workforce Development Strategy 2015-2018 noted that "Currently the mental health sector employs consumer workers…While the AOD sector employs many people with lived experience, few are employed in consumer worker roles" It identified a need for the alcohol and other drug sector to further understand and develop peer work roles and recommended action to examine "the potential for consumer worker roles in the alcohol and other drug field (as has occurred in the mental health field), including the development of role definitions and capabilities"[20]. However, the Workforce Development Strategy supports implementation of the overarching National Drug Strategy 2017-2026, and peer work is not identified as a priority within the Strategy[21].

Uptake of the Peer Workforce in Western Australia

The mental health and alcohol and other drug peer workforce within Australia has been deployed to some extent for several decades in Western Australia. This has been accompanied by significant policy, advocacy and capacity building efforts to grow the peer workforce- but hampered by limited prioritisation in system reform efforts and poor data collection to monitor progress.

There is a shortage of statistical information on the size and characteristics of the peer workforce for mental health and alcohol and other drug services. Peer workers are not recognised as workers by the Australian Institute of Health and Welfare (AIHW) for health workforce data collection purposes, and thus peer workforce rates are not available for primary care or private hospital settings[22]. The current workforce data analysis tool being used by the disability services sector to measure NDIS related workforce changes also does not collect peer workforce data[23]. AIHW mental health workforce data sets include peer workers but are restricted to public specialised mental health services and thus do not capture mental health workforce data within private and community mental health services.

Where data is available, it highlights that peer workforce uptake has been limited in Western Australia. For the 2013-14 financial year, less than 5% of the total Western Australian Mental Health Commission funded community managed mental health service delivery workforce were peer workers[24]. In 2014-15, peer workers accounted for less than 0.2% of public clinical mental health service delivery workforce[25].

No equivalent and recent data set could be identified for alcohol and other drug services, with the most recent data from 2002 indicating peer workers as 3.3% of the overall workforce[26]. 27% of organisations in the alcohol and other drug sector recently consulted by peak body WANADA utilised peer support roles, but it is unclear how many of these are paid or ongoing positions[27]. The number of peer worker roles was not identified but only 2.5% of alcohol and other drug workers identified as 'other' (potentially peer workers) among 163 workers completing the survey[28].

Although primary health networks have enabled regional funding for community mental health workers, including peer workers, to enhance primary care outcomes within specific programs and projects, the WA Peer Supporters' Network has no membership from, and is unaware of, any peer workers employed within primary care clinics or in private hospital settings. A summary of data availability is shown in Table 1.

Table 1. Summary Data Availability- Peer Workers as a Proportion of the Overall Workforce

Workforce Type	National	WA
NDIS	-	-
Primary Health	-	-
Private Mental Health Hospitals	-	-
WA Public Clinical Mental Health Services	0.2%	
Community Mental Health Sector	<5% (Partial data, data 3 years old[1])	-
Alcohol and Other Drug Sector	<2.5%	3.3% (Data 16 years old)
Mental Health Sector	-	-
Health Sector	-	-

[1] The MH NGO Minimum Data Set only collects data on peer workers employed under Mental Health Commission of Western Australia's funded service contracts. See Reference number 24 for data source.

Methodology and Response Rates

Methodology

The study explored the peer workforce from the perspectives of different stakeholder groups using tailored surveys (an individual, family member and carer survey; a peer worker survey and a manager's survey). The individual, family member and carer survey asked questions to gauge the perceptions of individuals, family members and carers about the peer workforce, including extent of awareness, interest, access and experiences of peer work. The peer worker survey gathered peer workers' employment profiles and information on satisfaction, wellbeing and retention rates and the relationship of these to workplace factors. The managers' survey explored employers' attitudes and readiness for peer workers and identified what they perceive as barriers and enablers of peer workforce growth for their organization.

Links to the survey were disseminated to mental health and alcohol and other drug service consumers, families, carers and providers via key sector newsletters and additional email and social media distribution lists over a 6 week period. The survey was also promoted at mid-point through a conference presentation of interim findings. Response rates for different stakeholder groups were monitored at several points over the survey period to target additional promotions.

Response Rates and Peer Workforce Profile

A total of 154 stakeholders completed the survey, including:

- 26 agency/organisational representatives (persons with a role in establishing and/or overseeing a peer workforce)
- 58 peer workers
- 70 individuals, families and carers

By Sector/ Type of Experience

73% of responses (159) overall were in relation to mental health services and 27% (58) were in relation to alcohol and other drug services. The total of 217, which is greater than 154 survey respondents, reflected that peer workers could identify more than one sector of employment of past and current employment and individuals, families and carers could identify more than type of lived experience (co-occurring mental health and alcohol and other drug use experiences). Of those completing the individual, family member and carer survey rates of co-identification as an individual and family member/carer of someone with mental health and/or alcohol and other drug issues was very high: 81% had family member/carer experience and 91% had individual experience (Table 2).

Table 2. Number of Respondents by Type of Experience/Sector of Employment

	Individuals, families and carers (types of experience)	Service Managers (primary sector of service)	Peer Workers (Sector/s worked)
Mental Health	89	20	50
Alcohol and Other Drug	33	6	19
Total- combined representative experiences	132	26	69
Total -number survey respondents	70	26	58

By Region in Western Australia

Response rates for metropolitan region were 67% (116) and 23% (75) for regional, rural and remote. Organisations and peer workers could identify both metropolitan and non-metropolitan service delivery locations and peer workers were asked which locations they had worked in as a peer worker (i.e. potentially both metropolitan and non-metropolitan across their work history) so the number of respondents is greater than total survey respondents (Table 3).

Table 3. Geographic Area Response Rates

	Individuals, families and carers	Service Managers- location of services provided	Peer Workers- locations worked in as a peer worker
Metropolitan	47	9	38
Regional, Rural and Remote	23	7	9
Both	NA	10	11
Total	70	26	58

The Service Provider survey was open to mental health or alcohol and other drug staff who have a role in decisions about the current or future peer workforce (such as HR personnel, Managers and Staff Supervisors). 26 staff completed the survey. Survey response profiles are as follows:

Service Provider- Type of Organisation and Role

Type of Provider

- 10 (38%) worked for a government agency
- 16 (62%) worked for a non-government organisation
- 0 (0%) worked for a for-profit organisation

Type of Role

- 15 (58%)- Workforce supervision and coordination of the workforce, e.g. Service Coordinator or Supervisor
- 13 (50%)- Workforce planning and decision-making, e.g. HR Manager, Executive, Senior Manager
- A minority of respondents (8%) identified both functions as part of their role.

Peer Worker- Type of Organisation and Role

Of peer workers completing the survey, 50 of 58 peer workers (86%) were currently in a peer role. Peer workers' terms of employment (e.g. volunteer, casual, part-time) were also obtained and are discussed in a later section of this Report on Workforce Sustainability.

Information was sought about peer workers' employment background and profile.

Peer workers were asked about which roles they had worked in as a peer worker, and could also select 'other'.

Consumer-Carer Peer Worker Overlap

- 46 (80%) had worked exclusively as a consumer or carer peer worker.
- 12 (20%) had worked as both a consumer and carer peer worker.

Sectoral Peer Worker Distribution and Overlap

- 7 of 58 had worked in the alcohol and other drug sector only
- 39 of 58 had worked in the mental health sector only
- 12 had worked in both sectors

Additionally, peer workers had worked in the following sectors: primary care (n=1); NDIS (n=1); domestic violence (n=1); arts and health (n=1); gender and sexual diversity (n=1).

Peer Worker Distribution Across Types of Employer

Peer workers could indicate more than one sector worked in as a peer worker.

- 47 had worked in not-for-profit services
- 25 had worked in government services
- 3 had worked in for-profit services.

43 had worked in only one type of service (74%) and 15 had worked across multiple types (26%).

Distribution of Types of Peer Work Role

Peer workers were asked to list the types of role they had been in employed in and could also list 'other'. Counting all past and current roles listed by peer workers, the types of peer roles were:

- 43% Consumer Peer Support Worker
- 25% Consumer Advisor
- 15% Carer Peer Support Worker
- 9% Carer Advisor
- 8% Other (including peer managers, peer group facilitators and peer workers in other sectors, such as LGBTIA, domestic violence)

Excluding 'other roles', 68 were consumer roles and 24 were carer roles. Peer workers had often worked across different types of peer work role. 30 had worked in 1 type of role (52%), while 28 (48%) had worked across 2 to 5 types of peer work role.

Peer Work Demand, Supply and Uptake

Summary of Findings

Peer Work is a desired and beneficial support option. Around 9 in 10 of individuals, families and carers surveyed reported they would peer support would benefit them and also supported having choice of access to a peer worker in services. While broader surveying of participants is required, the results provide a preliminary indication that the current supply of peer workers is insufficient to meet demand within mental health and alcohol and other drug services. There is a need to improve ease of access to peer workers and peer support options, and a need to grow awareness and understanding of peer work roles among individuals, families and carers. Based on manager and peer worker responses to the survey, there is no evidence that the peer workforce is expanding to meet participant needs.

Peer workforce growth can be constrained by worker supply, job shortages or lack of demand. As will be discussed in the Sustainability section of this report, there are a shortage of peer work jobs relative to supply of workers. While acknowledging that peer workforce growth relies on ongoing supply of peer workers, and development of equivalent vocational training pathways across the mental health and alcohol and other drug sectors, job shortages are the most critical factor underpinning lack of peer workforce growth. Mismatch between demand, supply and uptake of peer work highlights the importance of targets and strategies for peer workforce growth. The Peer Workforce Study illustrated the potential for consumer, family and carer surveying as a method for evidence-based estimations of peer workforce growth requirements.

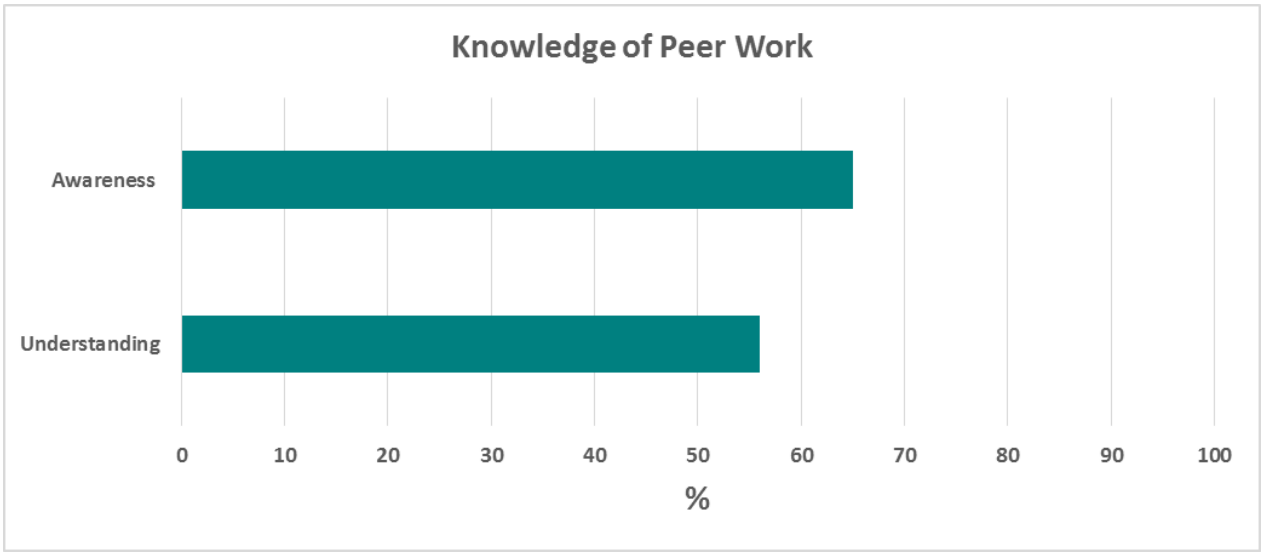
Demand for Peer Work by Individuals, Families and Carers

Peer workforce demand was ascertained through the individual, family and carer survey. Questions gauged awareness, understanding, attitudes towards and extent of access to peer work.

Awareness and Understanding of Peer Work

The majority of individuals, family members and carers had heard about peer workers prior to completing the survey, with 65% having heard about peer workers (Fig 1). Self-rated understanding of the peer work role was slightly lower, with 56% of respondents stating 'they know how a peer worker helps people'. Rates of awareness and understanding are likely to be higher in this survey than the general population, as the survey was also promoted through community mental health distribution networks with a likely greater response rate by individuals, family members and carers already engaged in services.

Fig 1. Extent of Knowledge About Peer Work by Individuals, Families and Carers

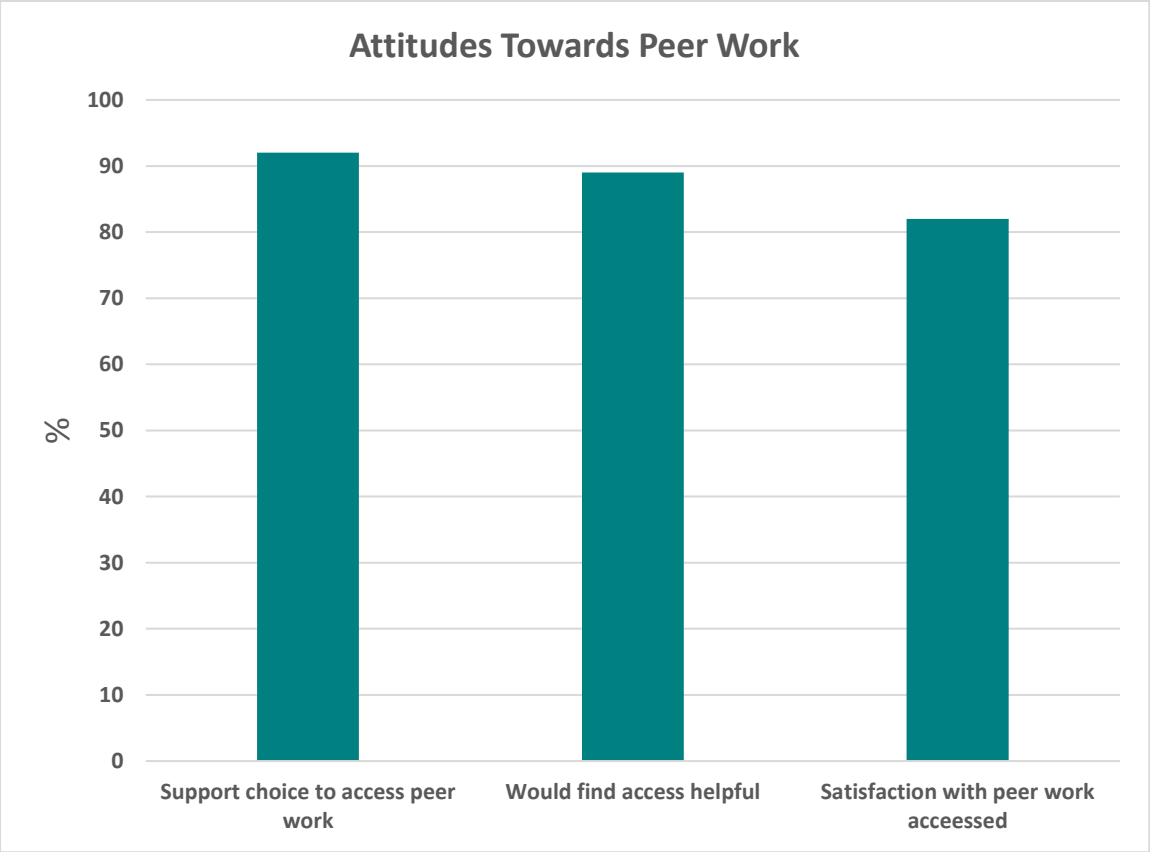


Attitudes Towards Peer Work

Nearly all individuals, family members and carers (92%, n=61) felt that people should have the choice to access a peer worker in services. Only 1 person did not support choice, while 4 were unsure. As it

was predicted that many people answering the survey would have had limited understanding of peer work, questions about whether the person would find it helpful to "connect with someone with similar experiences" were asked as an indicator of attitudes towards peer work. 89% (59) of individuals, family members and carers reported that, in general, they found it helpful to connect with people with similar experiences, with only 1 respondent not finding this helpful and 6 unsure (Fig 2).

Fig 2. Attitudes and Satisfaction Rates of Individuals, Families and Carers



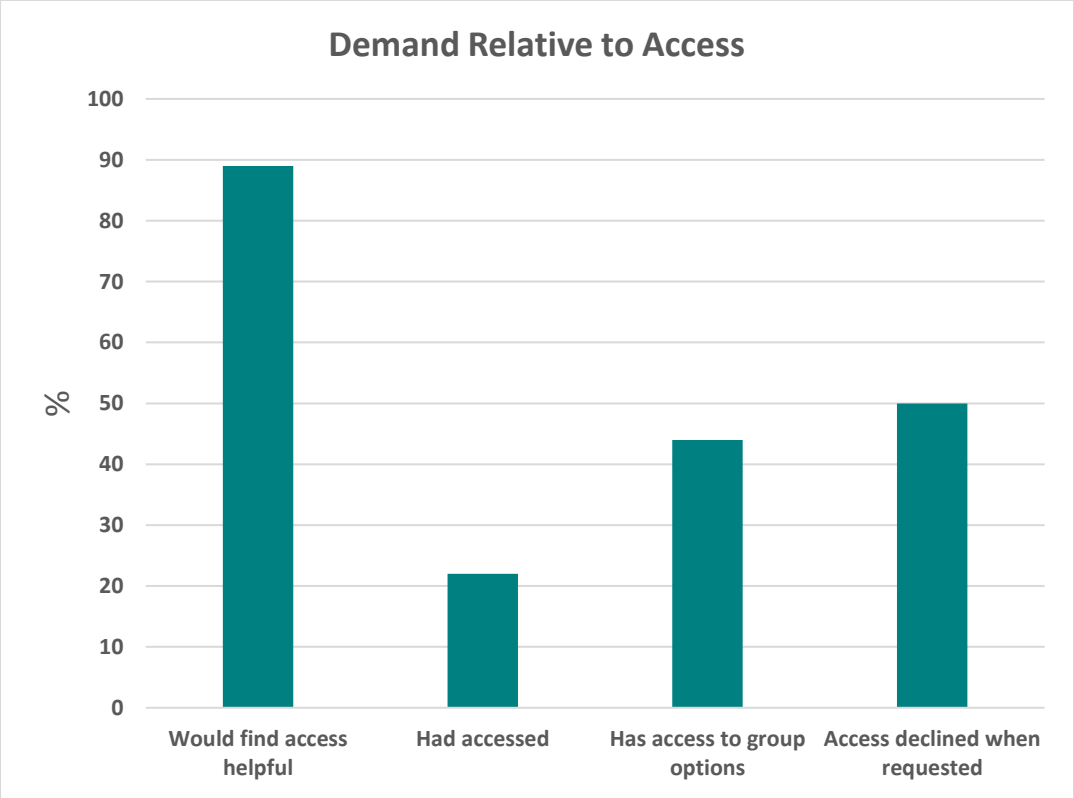
Individuals, family members and carers were also asked whether they were *currently* facing challenges where it would be helpful to talk to someone with a similar experience, and if so, how they felt this would help. This question aimed to understand the extent to which people would currently benefit from peer support. This is important to assessing the likelihood of uptake and demand for peer workers if it was offered by services. Of 47 responses, 39 (83%) reported they would find talking to a peer helpful, with 4 (8.5%) undecided and 4 (8.5%) reporting that it would not be helpful. That is, most of the respondents (83%) would have benefited from accessing peer work at the time of survey completion. Of the four respondents who didn't feel it would be helpful, 1 did not find it helpful to

talk to others generally, 1 felt there was not enough in common between individuals with lived experience, 1 gave no comment, and 1 liked to share experiences with 'everyone' (i.e. not just peers).

Access to Peer Work

The individual, family member and carer survey also assessed extent of access to peer work and peer support options (Fig 3). The majority of individuals, family members and carers (71%) had never been asked by a service if they wanted to speak with a peer worker and only 22% had received support from a peer worker. 27% (18 respondents) had tried to access a peer worker, and for 50% of these (9 people) the service had stated it could not provide a peer worker. In addition to individual peer work, volunteer peer workers may offer peer support through community-based support groups. Respondents were therefore asked whether support groups were available in their local area to connect with others with similar experiences. 44% (29) had access to local support groups, 26% (17) did not have access, and 30% (20) were unsure. This indicates that it can be difficult to navigate peer support options and lack of access to local groups, as well as lack of access to paid peer workers, is quite a common experience.

Fig 3. Demand for Peer Work Compared to Access



Individuals, family members and carers were invited to offer general comments or feedback on the peer workforce. All comments (n=36) fell into one or more three categories: the person shared their support for access to peer workers (10 comments), spoke of the need to improve access and/or availability of peer workers (8 comments), or made suggestions for improving the peer workforce (6 comments).

Suggestions for improvement included: ensuring fidelity to peer approaches (e.g. the Intentional Peer Support approach); ensuring peers were flexible to understand differences between people's experiences; training in leadership and development to peer workers and teams that hire peer workers; increasing consumer and staff understanding of peer work; and providing adequate training and information to peer workers.

Example comments relating to *support for the peer role* were:

> *Peer work is really important and more organisations need to see the gold that can come out of a person's lived experience*
>
> *I think they should be suggested to all carers by the Mental Health Centre's*

Example comments on the need to *improve access and/or availability* were:

> *Why do I not know [about peer work] when I am in a position of needing to know- how well disseminated is this info?*
>
> *I have found the process of obtaining…any form of clear information, let alone access, to a peer worker confusing, draining and pointless.*
>
> *I would like to meet one! It would be good if agencies informed people of their availability.*

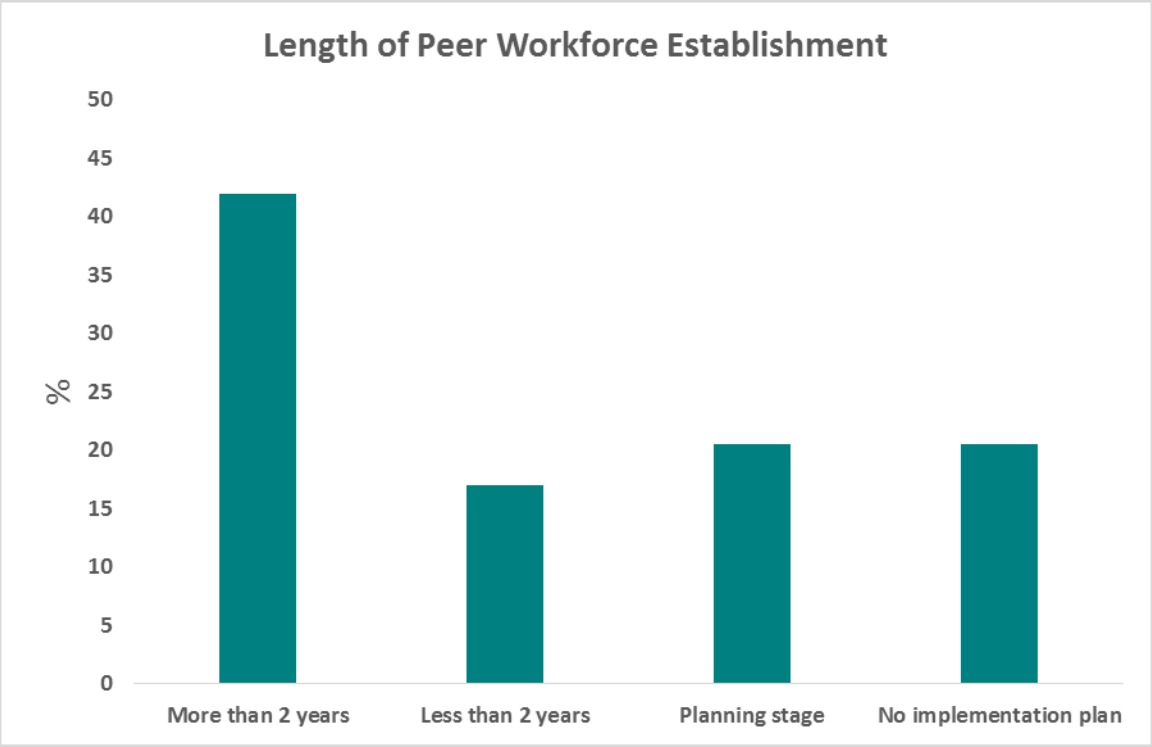
These comments echo the overall findings of high levels of support for peer work approaches among individuals, families and carers, together with a need to improve understanding of, navigation and access to peer workers.

Peer Workforce Uptake

Duration of peer workforce employment by agencies/organisations and duration of peer work employment by peer workers can be used as an indicator for peer workforce growth, with increasing numbers of recent and planned peer workforces reported by organisations, and increasing number of peer workers new to the industry, indicating sector growth. Survey response data did not provide evidence of peer workforce growth.

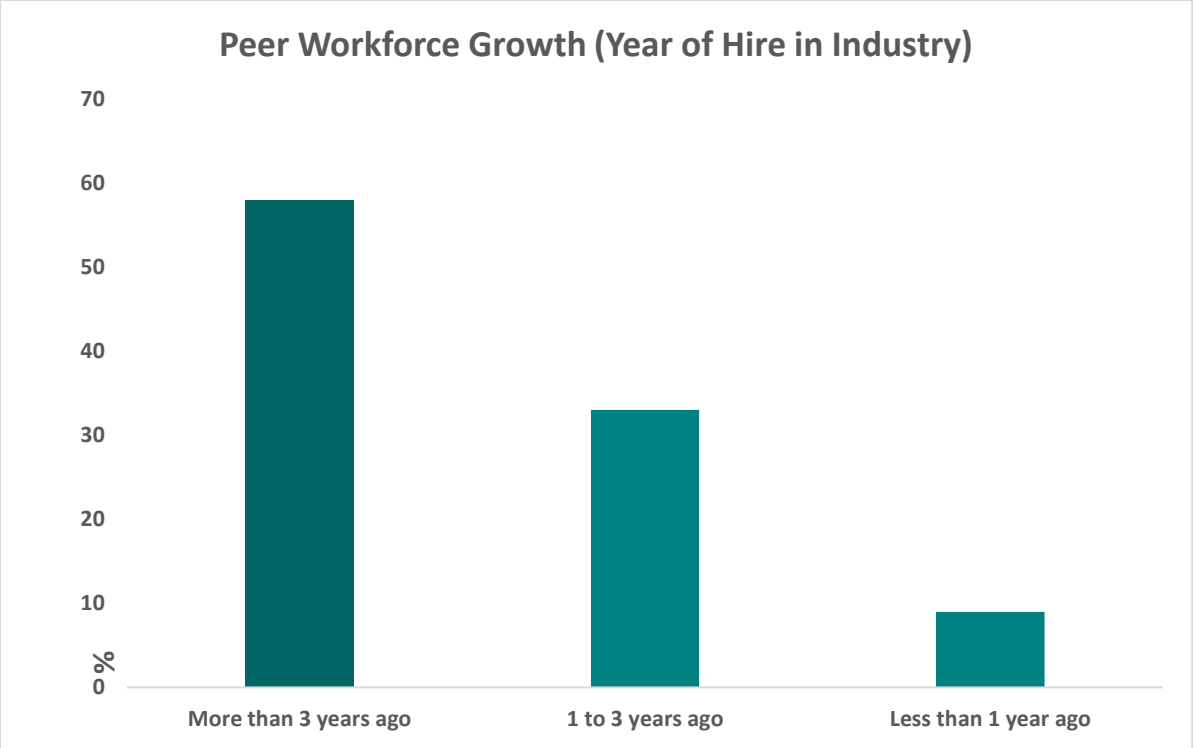
The majority of those employers who employed peer workers had been hiring peer workers for 2 or more years (71%), compared with 29% establishing the peer workforce less than 2 years ago (Fig 4). There were fewer organisations currently planning and preparing for peer work than would be expected if the peer workforce was in a period of active growth.

Fig 4. Organisation's Peer Workforce Establishment History



Peer Workers' year of hire indicated a 'decline curve' rather than a growth curve for the peer workforce. 59% had commenced peer work more than 5 years ago, 33% had commenced peer work 1 to 3 years ago and only 8% of respondents had worked as a peer worker for less than a year (Fig 5).

Fig 5. Peer Workforce Growth (Year of Hire in Industry)



Discussion: Implications for Peer Work Planning

Job Availability is the Limiting Factor for Growth

Peer workforce growth challenges may be caused by three main factors: lack of worker supply (skilled worker shortage), lack of service user demand or lack of employer uptake. The individual, family and carer survey indicates service user demand for peer work is not the cause of limited growth. The Mental Health Commission of WA has funded scholarships for Cert IV Mental Health Peer Work for three successive years, and because of this, while ongoing mechanisms to grow an available, qualified and skilled workforce are important to peer workforce growth, access to skilled workers is unlikely to be a critical constrained to workforce growth. As will be outlined in a later section of this report on Workforce Sustainability, peer workers are greatly concerned about lack of job opportunities, volunteerism (lack of paid employment opportunities) and a mismatch between preferred and actual working hours indicative of limited job options. These findings indicate that job supply is the most

critical factor constraining peer workforce growth, and that government investment in training to grow supply of a skilled peer workforce needs to be matched with job creation efforts.

It is also becoming evident that there is a need to plan for equal supply of skilled peer workers across mental health and alcohol and other drug services through reviewing vocational competencies. The majority of peer workers who took part in the survey were working within the mental health, rather than the alcohol and other drug sector. While many students of the Cert IV Mental Health Peer Work have relevant personal and/or family experiences to use their skills within both sectors and value this qualification, the Cert IV only has one alcohol and other drug specific unit, with no publicly available preliminary training or Cert IV qualifications available for alcohol and other drug peer work. Equivalent vocational opportunities and worker supply arrangements are needed for both the mental health and alcohol and other drug sectors, with consideration of how to optimise these given that dual experiences of both mental health and addictions are the norm, rather than the exception, for people using services.

Towards Appropriate Workforce Growth Targets

As part of the 2014 National Review of Mental Health Programmes and Services, the National Mental Health Commission engaged Human Capital Alliance (HCA) to develop a report on national mental health workforce requirements[29]. The authors noted that peer workforce growth targets are essential to achieving growth. While aspirational but arbitrary targets are necessary in the absence of evidence-based methodologies for estimating how many peer workers will be required in future, HCA recommends work is undertaken to analyse population needs, in line with the general approach to estimating health workforce supply needs. The authors stated "*Does lived experience help with the recovery process? The minimal use of peer workers would be determined by the answer to that question*"[30].

While HCA recommended a needs analysis methodology based on a representative audit and analysis of care plans, the question is who audits, and who could reliably know from this method who will accept a peer worker if offered? Directly engaging with individuals, families and carers to ascertain whether they

would benefit and under what circumstances is a more respectful and potentially reliable method aligned to consumer and carer participation standards[2].

The Peer Workforce Study was unique in directly asking who would benefit from peer work in order to estimate demand and achieving a first estimate of demand of 87% of service participants in WA mental health and alcohol and other drug services. This estimate is highly promising but should also be taken with caution due to sample size (n=37), and broader surveying is recommended to develop accurate workforce modelling and targets for growth. There is also a need to understand factors affecting likelihood of actual uptake among participants who report they would benefit, such as preferred frequency, extent and method of engagement with peer support. Due to the urgent need for growth in the peer workforce, interim growth targets should be set prior to a more accurate demand estimate becoming available.

[2] The HCA report goes on to identify a need to develop a methodology to estimate demand for peer workers who do not provide direct support, but are in roles that facilitate cultural change within services, based on analysis of cultural change requirements.

Peer Work Growth Enablers and Barriers

Summary of Findings

Services are expected to grow the peer workforce within an overall shortfall of government commitment and investment. All respondents felt that stronger government leadership and commitment would be helpful. To make peer work widely available across the mental health and alcohol and other drug sector, clear government commitment and leadership must be signalled to the sector through policy commitments and strategic commissioning approaches that overcome contractual barriers, introduce funding streams and incentives, and ensure sectoral capacity building mechanisms are sufficient for supply, uptake, retention and quality of the peer workforce.

Barriers

Service managers were asked about the main challenges, if any, that the organisation had faced in hiring peer workers. Those that had not yet employed peers reported greater challenges on average than those that had already hired peer workers. Challenges, ranked from most to least frequently reported, are shown in Table 4.

Taking into account all challenges- those reported as either significant or major- funding constraints and lack of funding incentives were the most commonly reported barrier. 75% reported peer work not being a priority in sector contracts, grants and standards as a barrier to hire. 39% of respondents reported that their contracts do not permit peer work hire- i.e. they would need to seek alternative funding or would require the funder to amend the contract in order to hire peer workers.

Service could rate challenges as major, minor or not a challenge. Of major challenges, financial barriers were again the most commonly reported major challenge, with insufficient surplus funds being a major barrier for 36% of respondents, and lack of priority in contracts and grants a major barrier for 18% of respondents.

Table 4. Challenges Faced in Hiring a Peer Workforce

Challenge	Ranking	% Significant or Major Challenge	% Major Challenge
Financial Not a priority in sector contracts, grants and standards	1	75%	18%
Financial Insufficient surplus funds for peer workforce hire	2	68%	36%
Developmental Lack of external guidance (e.g. resources, training, networks)	3	61%	9%
Developmental Concerns about risks associated with the peer workforce	4	53%	5%
Developmental Lack of internal expertise	4	53%	14%
Financial Our current service contracts do not permit peer workforce hire	5	39%	14%
Culture/Leadership Too many other changes/reforms happening in the service	5	39%	9%
Culture/leadership Staff resistance to having consumer/service users as part of the workforce	5	39%	9%
Culture/leadership Lack of senior/executive support	6	37%	14%
Developmental Things went wrong when we hired peer workers in the past	7	10%	0%

These findings support the position previously adopted by a broad stakeholder group from mental health and alcohol and other drug sectors in Western Australia, in the WA Peer Work Strategic Framework (2014, p.12):

> *"Peer work and peer workers require a secure funding base. Development of the peer workforce requires dedicated and secure funding that is equitable with other services. (O'Hagan 2011). Secured and recurrent funding is needed to provide for the growth and interest in peer work, and to address the need for defined career pathways and adequate pay and conditions for peer workers."*[31]

Consideration should therefore be given to establishment grants to assist new entrants to peer work service delivery as these arise. Consideration should also be given to looking at multiple options for peer workforce growth, as the addition of ad hoc peer workers to pilot programs and services will led to limited growth is not accompanied by establishing dedicated peer teams, programs and services within the suite of sectoral programs and services available.

An additional challenge to establishment grants is similar to that face generally by sector capacity building grants, which are often delivered over time frames too short to fully embed and sustain sectoral change. Historically, peer workforce development initiatives have provided assistance to the sector over timeframes that are insufficient to embed and sustain a reliable system of peer workforce supply, uptake and quality. The provision of ongoing sectoral supports through which peer employers can access expertise, resources and training as required- whether newly establishing a peer workforce or developing an existing workforce- would add sustainability and impact to establishment grants. The toll on employees and employers of limited access to external supports is discussed further in a later section of this report on Workforce Sustainability.

Enablers

Service providers were asked to choose from a suite of options according to what would be helpful to the organisation hiring and retaining peer workers (Table 5).

Table 5. Options that Would Assist Service Hire and Retention of the Peer Workforce

Enabler	% Responses ('Very Helpful')	% Responses ('Helpful or very helpful'
Financial Grants to assist in establishing the peer workforce	70	100
Culture/Leadership Clear government commitment to increasing the peer workforce	67	100
Financial Peer Workforce included in design of future service tenders/grants	61	100
Developmental External supervision and wellbeing support for peer workers	56	94
Developmental External guidance and advice e.g. resources, tools, networks	50	94
Financial Changes to current contracts to permit peer workforce hire	47	80
Developmental Training in peer workforce development	45	100

There were no marked differences between enabling strategies, with similar high ratings of each strategy as helpful or very helpful. Funding measures to boost the peer workforce were more often reported as "very helpful" compared with other types of resources and supports. Interestingly, the majority of services reported that access to external supervision and support for peer workers would

be very helpful (56%) and outranked external guidance, advice, resources and training. This may indicate that employers are aware of, and being impacted by, the workforce wellbeing issues we discussed in the Report section on Workforce Sustainability.

Benefits of the Peer Workforce

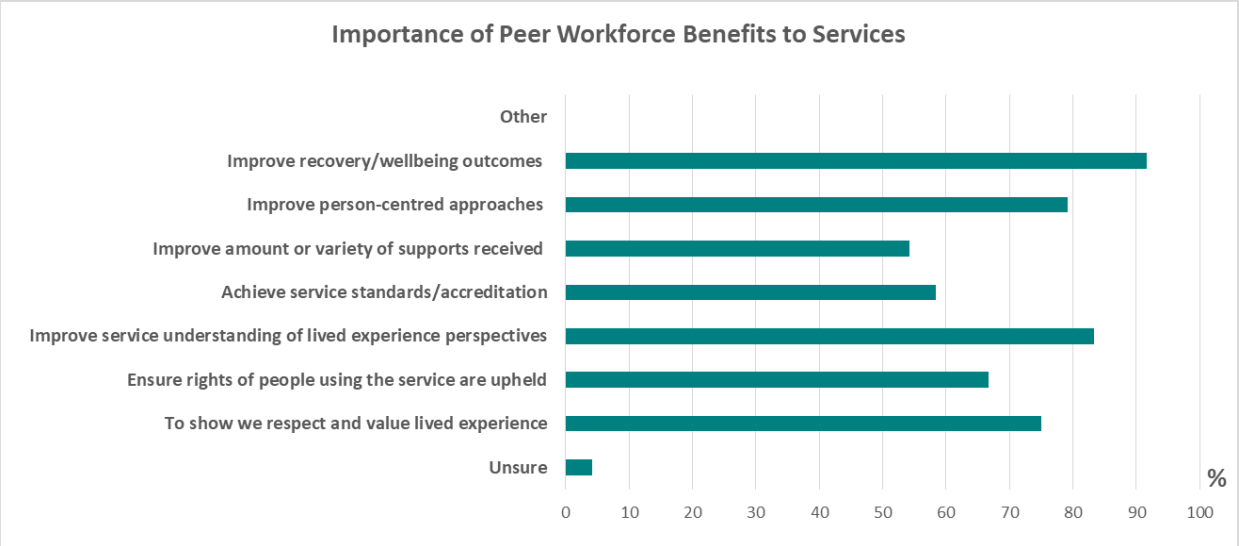
Summary of Findings

83% of individuals, families and carers who had accessed a peer worker reported positive experiences. Individuals, families and carers want to access peer support to enhance service navigation, problem-solving, goal achievement, self-advocacy and self-worth, and benefit from the non-judgmental listening, empathy and sharing of life experiences from someone who has been in a similar situation. Peer support was also seen as important for a range of life issues, such as for employment and workplace issues, family relationships, legal issues and community inclusion. When asked to identify which peer workforce benefits were relevant to their service, improved person-centred care, recovery and wellbeing outcomes and lived experience understanding were particularly important.

Benefits to Services

Services were asked to identify, from a list of peer work benefits identified from existing literature, which benefits were important to their service.

Fig 6. Importance of Peer Work Benefits to the Service



The percentage of respondents who felt these benefits were relevant to the organisation are shown in Fig 6. Improved person-centred care, recovery and wellbeing outcomes and lived experience understanding were particularly relevant to the service. Increasing or diversifying supports, achieving standard/accreditation and reducing delivery costs were less often rated as important.

While service providers were not directly asked about the outcomes of peer workforce hire by their service, they were invited to provide general feedback about the peer workforce. No negative feedback was provided. Examples of positive feedback included:

> *The most significant change in alcohol and other drug and mental health service delivery for good outcomes I have seen in my 20years+ career.*
>
> *It is vital to any agency to have some level of peer work, whether it be volunteer or paid peer workforce. Providing peers with real support and supervision is a very important risk mitigator to the agency and increases retention of peers.*
>
> *Very beneficial to the organization.*
>
> *Incredibly valuable part of our team, the consumers connect on a much deeper level with lived experience staff and they have the ability to instil hope in others. I believe Peer Support workers are utterly priceless and our department would not be able to offer our service without them.*
>
> *Recognition is vital. Recognition of them as peers and also of the vital role they play within the agency. The work of the peer is often more difficult than for "professional staff" and therefore often requires more time input from the agency to make sure both peer and consumer are being "looked after".*
>
> *Peer Workers bring another layer of skill and expertise to both customers and colleagues.*
>
> *They bring stuff someone like myself who hasn't had illness just doesn't understand.*

Benefits to Individuals, Families and Carers

People participating in the survey were asked to comment on their experiences where they had accessed support from a peer worker. These were then classified into positive, negative or mixed

experiences of peer work. 83% (19) people reported positive experiences, 4% (1 person) reported a negative experience and 13% (3 respondents) had mixed experiences. These mixed or negative experiences included: differences between the quality of individual peer workers, different atmospheres between individual peer support groups, disbanding of a peer support group, and lack of follow through by a peer worker on an agreed action.

Positive experiences included experiencing hope, feeling understood, and feeling able to be more open and ask questions without being judged, as a result of the relationship. Example quotes from participants were:

> *They made it really easy to open up and ask any questions that are sometimes tricky to ask a clinician*
>
> *I felt completely understood, no question too stupid, etc and I knew that there was real hope if I just kept trying. The biggest and best thing about working and talking to/with someone you know is living a fulfilling and successful life in recovery, is definitely hope. They are not quoting an info source or a statistic, they are telling you how it was for them, warts and all.*
>
> *They understood what I was going through on my level not text book*
>
> *I had a peer worker for healthy walking. They were awesome and helped me not be scared to do things.*
>
> *At first, I was anxious, before starting to open up when I realized this person in front of me had the same similar experiences that I went through and wasn't some person who was quoting a book phrase.*
>
> *To know that someone has gone through a mental health crisis and came out the other end gave me an extreme amount of hope that I too could recover.*

Individuals, families and carers who were currently experiencing challenges where it would be helpful to talk with someone with similar experiences (i.e. peers), were asked how this would be helpful to them. The 39 respondents who felt peer support would be beneficial to their current situation

commented on the type of challenges they would like help with as well as they ways peer support would be helpful.

They types of challenges survey participants would like to talk to a peer about included problems in the workplace, return to work support, addictions, mental health issues, family and relationship challenges, supporting the person they care for (carer and family member support), legal/court issues and speaking with health professionals. These highlight the diverse service contexts where peer support may be of benefit as well as the holistic approach that individuals, families and carers are seeking when accessing peer support.

People reported various ways that peer support would be personally helpful to them. These included: finding and accessing services, greater carer understanding of what the person they care about is experiencing, feeling understood and listened to with empathy, having someone to speak with, not being judged, feeling less isolated and alone, exploring strategies others have used (coping and problem-solving), being treated as an equal, support to grow confidence, having support that does not involve unwanted advice, having things explained in plain language (translating jargon), developing a sense of hope, having assistance to speak up (self-advocacy), reducing frustration, growing self-acceptance, companionship, opportunities to do things together with someone else and having access to an alternative, informed perspective on their situation.

Workforce Sustainability: Satisfaction, Retention and Wellbeing

Summary of Findings

75%, or 3 in 4 peer workers, reported feeling satisfied in the workplace overall. Peer work provides a greatly fulfilling vocation and is a highly promising strategy for enhancing wellbeing outcomes for individuals, families and carers.

This potential is not currently utilised with poor job vacancies, remuneration issues and poor career pathways for peer workers. Although rates of overall satisfaction were high the majority of peer workers were dissatisfied with job opportunities, career pathways and access to a fair wage.

Peer workers are exposed to significant psychosocial health and safety risks in the workplace. 42% were dissatisfied with levels of stigma and discrimination in the workplace, a majority had taken sick leave for work-related reasons, and 1 in 5 had resigned for work-related reasons. The majority of (78%) of work-related reasons are attributable to peer workforce management problems, such as lack of role understanding, lack of executive support, poor supervision and lack of tailored/inclusive policies. Disturbingly frequent experiences of stigma, discrimination and bullying in the workplace highlight the need for immediate attention to and improvement of peer workplaces to support the health, wellbeing and retention of peer workers. Peer workers do not have the full suite of occupational regulation and representation that more established workforces do and bring experiences to workplaces that have traditionally been seen as undesirable, problematic or risky from a human resource management perspective. There is a need for government and employers to support additional safeguarding mechanisms for safety and equality of peer workers in the workplace, described within the report recommendations.

Peer Workforce Satisfaction

Overall Rates of Satisfaction

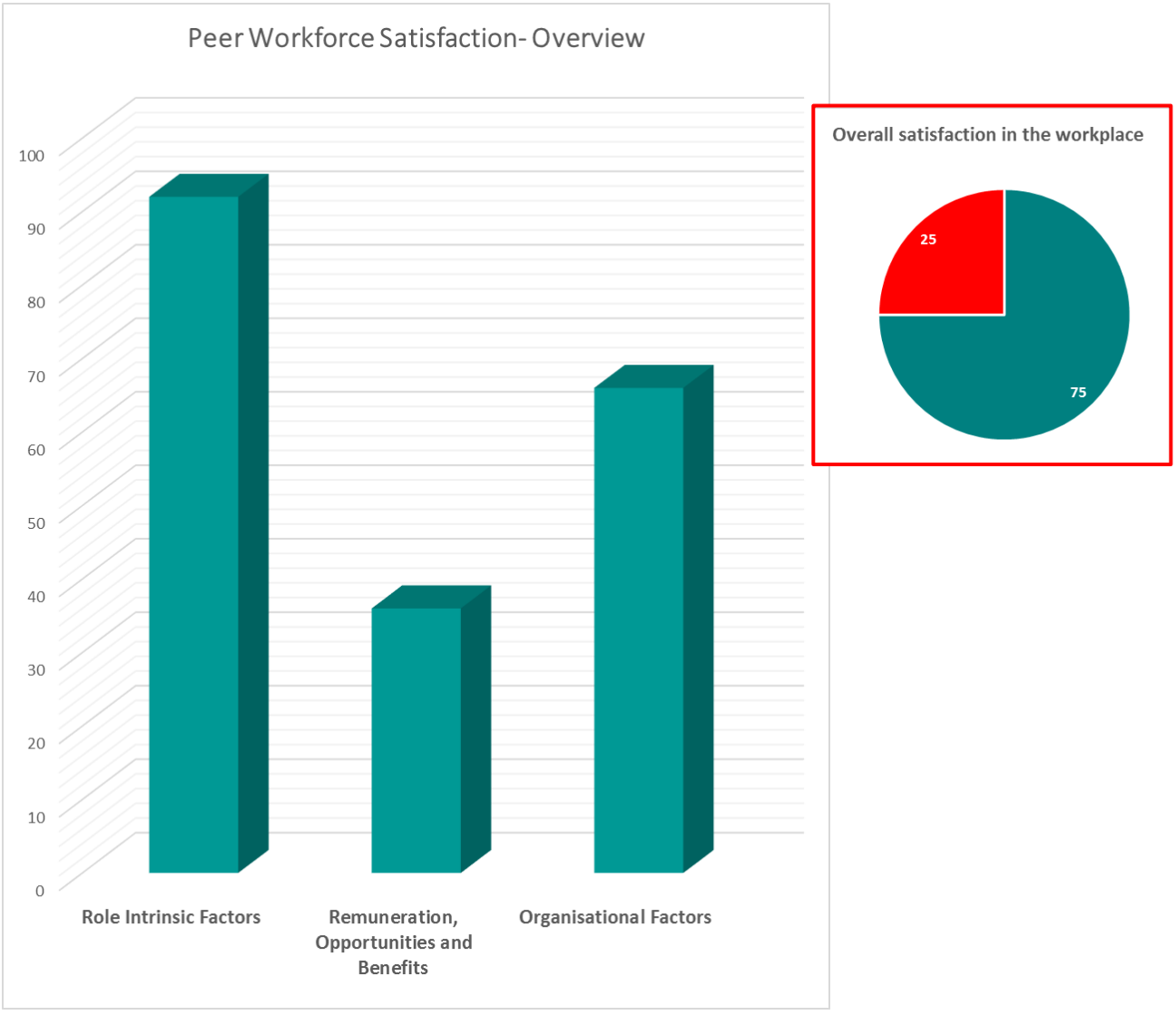
Questions developed for the satisfaction survey were based on three dimensions of peer work: the nature of the role; remuneration, opportunities and benefits (including employment status, job opportunities, perceived pay equality and progression opportunities); and organisational workforce factors. While non-exhaustive, 13 items were pre-selected and developed based on aspects of the role most frequently raised as important to peer workers with the WAPSN across 3 years of peer work meetings. These three dimensions are outlined below.

Table 6. Overview of Peer Work Satisfaction Domains, Satisfaction Rates and Survey Items

Dimension of Peer Work Role	Average Satisfaction Rating	Survey Items
Role Intrinsic Factors	92%	• Role autonomy/freedom • Making a meaningful contribution in others' lives
Remuneration, Opportunities and Benefits	34%	• Employment Status (volunteer, part-time, casual, full-time)- actual versus preferred • Peer work job opportunities in the sector • Perceived wage discrimination • Career progression opportunities
Organisational Factors	66%	• Access to role supervision and support • Extent of professional development/training • Levels of stigma and discrimination in the workplace • Inclusion and acceptance of peers in the workplace • Employers' flexibility to change work arrangements to meet wellbeing needs; • Extent to which values and ethical conduct are upheld in the workplace • Fair pay/salary of peer roles compared to non-peer roles

Fig 7 shows major differences in satisfaction between these three dimensions. Overall satisfaction rates across these combined areas were 75%, or 3 in 4 peer workers reporting overall satisfaction in the workplace. High overall satisfaction with peer work is further supported by peer workers' intentions to remain in the sector. Of peer workers currently working (50 of 58 peer workers), 6 (12%) intended to exit the peer role soon, while 40 (88%) intended to continue as a peer worker. Peer workers reported high satisfaction with role intrinsic factors; high dissatisfaction with remuneration, role opportunities and benefits, particularly role opportunities; and mixed/medium satisfaction for organisational factors.

Fig 7. Overview of Peer Workforce Satisfaction Rates



Role Intrinsic Factors

Role intrinsic factors consider vocational satisfaction, or a sense of the role being worthwhile to perform. Peer workers were asked to rate the extent to which they are satisfied that peer work enables them to make a meaningful contribution in others' lives, and the extent to which they experience freedom and autonomy within the role. Average satisfaction rate for this domain was 92% (96% making a meaningful contribution, and 87% satisfaction with levels of freedom and autonomy within the role) (Fig 8).

Fig 8. Satisfaction with Role Intrinsic Factors

Remuneration, Opportunities and Benefits

Peer workers were asked about their preferred and actual employment status, job opportunities in the sector, career progression opportunities and satisfaction with pay levels. The majority of respondents were *dissatisfied* in this domain, with an average satisfaction rating of 34%.

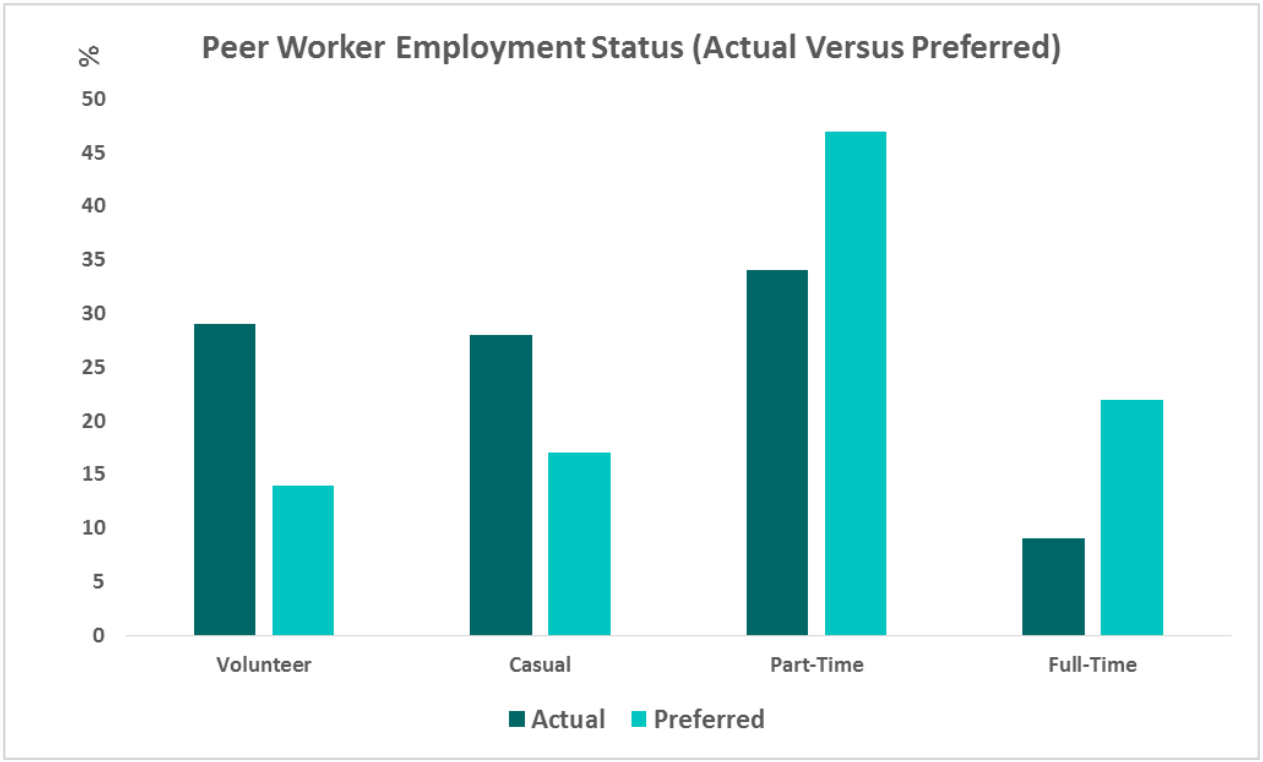
1. Employment Status- Actual Versus Preferred

Satisfaction with type of employment was ascertained indirectly by asking peer workers to select their actual versus preferred employment arrangements. A slight majority of respondents (53%) were not working in their preferred employment arrangement, resulting in an assigned satisfaction score of 47%. Peer workers hired for at least 3 years reported a match between actual and preferred employment type more frequently (64%) compared with peer workers with fewer years in the industry (44%).Nearly one

third (29%) of respondents were in volunteer roles, and the majority (57%) were either volunteer or casually employed. Compared with 34% in part-time employment, 47% would prefer part-time employment. For every 1 full-time role a further 2.4 peer workers would like to work full time (9% actual compared to 22% preferred). This finding may indicate a shortage of peer work roles leading to acceptance of non-preferred employment conditions.

Historically, peer work managers have often been encouraged to offer part-time employment for peer workers, however there is increasing recognition that as will all other staff, peer workers' employment preferences are individual. Five peer workers (all of who had more than 3 years experience) worked as a volunteer and preferred volunteering, while another five worked full time and preferred full time employment. Part-time and full-time position were overall more frequently preferred than volunteer or casual roles, but these results do highlight differences between individual peer workers in their preferred employment arrangements (Fig 9).

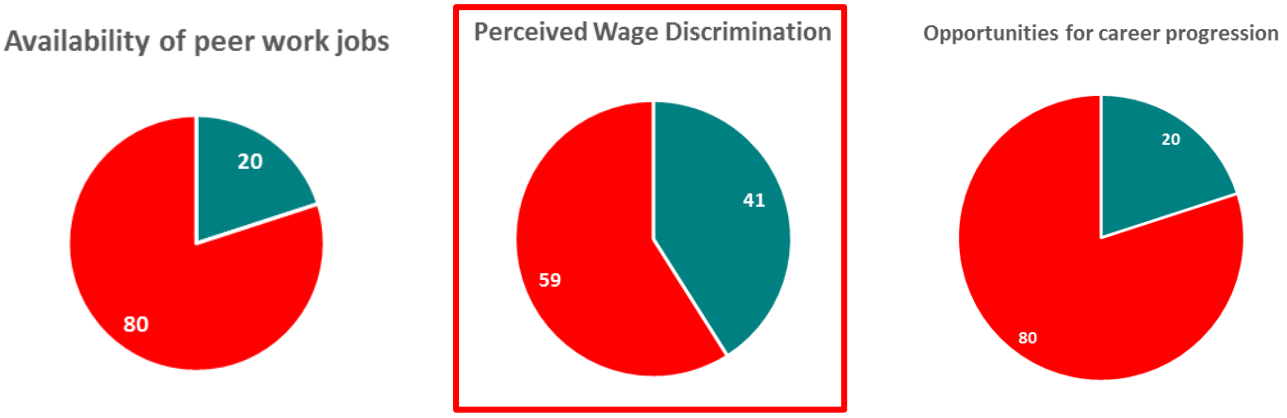
Fig 9. Actual Versus Preferred Employment Status



2. Job Availability and Opportunities for Career Progression

Peer workers were asked to rate the extent to which they felt there were job opportunities in the sector and opportunities for career progression. 80% were dissatisfied with the availability of peer work jobs, 80% were dissatisfied with opportunities for career progression, and 51% felt they experienced wage discrimination (were paid unfairly compared to non-peer roles). 27% were very dissatisfied with job availability, 27% were very dissatisfied with career progression opportunities, and 22% were very dissatisfied with wage equality (Fig 10).

Fig 10. Satisfaction with Job Opportunities, Progression Opportunities and Pay Equality



3. Equal Pay as a Component of Wage Satisfaction

Only one aspect of wage satisfaction, fair pay relative to non-peer roles within the organisation, was asked within the survey. This question was prioritised for inclusion in the survey due to multiple reports by individual peer workers over time to the Network of intentions to exit the peer role due to lower pay/salary relative to equivalent non-peer roles. Pay inequality poses risks to peer workforce quality and growth in the form of attrition of skilled workers from peer roles to better paid fields, and poses risks to employers and employees related to wage discrimination[32].

Survey respondents were asked about their level of satisfaction with "fair pay/salary of peer roles compared to non-peer roles". A majority (59%) were dissatisfied, compared with 75% overall satisfaction in the workplace, highlighting a need for clear, fair and transparent structures of pay for peer workers.

It is important to note that there are challenges in setting fair pay arrangements in terms of putting a monetary value on lived experience, and the implications of this for the broader workforce who have a mixture of non-peer work qualifications and lived experience. The Cert IV Peer Work pathway has provided some precedent for the sector to classify peer roles at an equal salary level to other positions requiring Cert IV level competencies within the industry. There is a need to consider how graduates from peer workforce pathways other than the nationally recognised training qualifications could be assessed for competency/skill level of graduates in assisting with wage classification.

4. Types of Peer Roles- Relative Uptake by Services

Services currently hiring peer workers were asked to provide an estimate composition of their voluntary and paid peer workforce, including direct support (peer support) and advisory (e.g. consumer representative roles). Direct support roles accounted for 62% (n=82) of peer workers, with 38% (n=54) peer workers in advisory roles. On average across employers, 68% of peer support roles were paid, while 58% of peer advisory roles were paid.

Across all types of roles, 36.2% were voluntary. Payment varied greatly between organisations, with 0-100% of support roles and 0-100% of advisory roles being volunteers depending on the service.

This volunteering rate of 36% is much higher than the rates of peer workers preferring volunteer roles (14%), further highlighting discrepancies between peer worker aims for remuneration for their time versus low or no-paid roles in the sector.

Peer work composition varied significantly between the 15 service providers responding to the survey:

- 67% deployed both direct support and advisory roles, 6.5% deployed only advisory roles, and 26.5% deployed only peer support roles. This means that some services have engaged peer workers to provide direct support to participants without necessarily having formalised mechanisms- such as consumer representatives, advisors or advisory groups- to support cultural change and embedding of lived experience at other levels of the organisation.

- Size of peer workforces varied from 2-26 peer workers, with a range of 0-20 peers in direct support roles, and 0-11 in advisory roles.

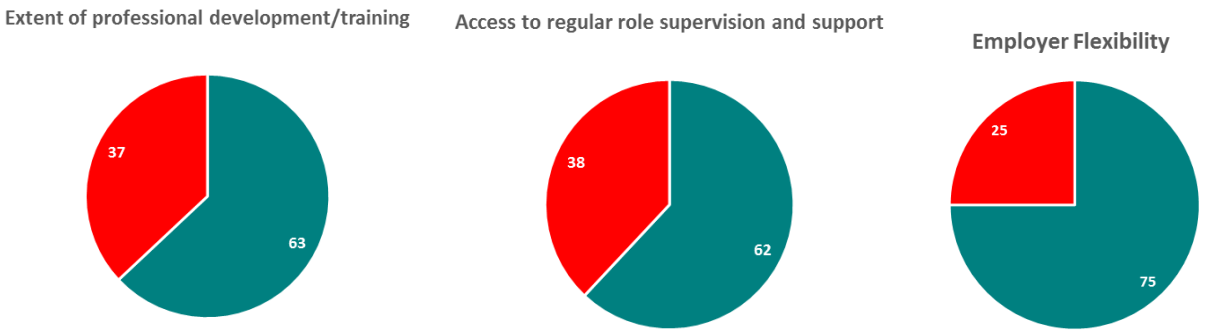
Organisational Factors

Domain 3: Organisational Factors- ***Peer Inclusive Workplaces***

This category refers to aspects of the work environment important to peer worker satisfaction within the workplace. The average satisfaction rate in this domain was 66%. Six questions were asked specific for organisational factors.

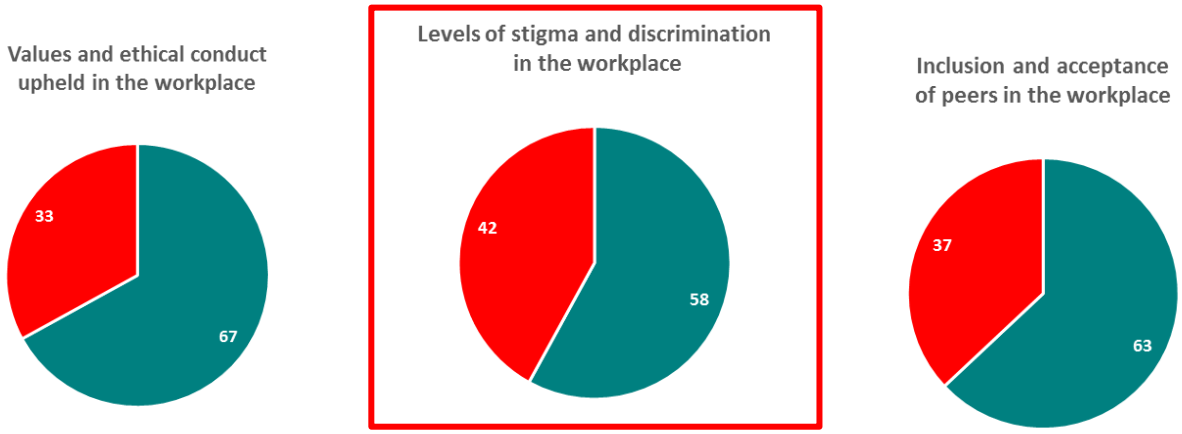
Three questions were asked about commonly reported aspects of the peer workers' experience of role management and support. Satisfaction with extent of professional development and training was 63%, 62% of peer workers were satisfied with extent of access to regular role supervision and support and 75% were satisfied with the employers' degree of flexibility to assist the person to change their work arrangements to meet their wellbeing needs (Fig 11).

Fig 11. Organisational Factors - Development, Supervision, Support and Flexibility



The remaining three questions within this category aimed to ascertain the extent of peer workers' satisfaction with the culture and values of their workplace. 63% were satisfied with the level of inclusion and acceptance of peers in the workplace, and 67% were satisfied with the extent to which values and ethical conduct were upheld in the workplace. The lowest satisfaction score in this domain was for levels of stigma and discrimination in the workplace, with only 58% of peer workers satisfied with their workplaces with respect to the level of stigma and discrimination encountered (Fig 12)

Fig 12. Organisational Factors - Ethics, Stigma and Discrimination, Inclusion and Acceptance



Retention and Presentism: Work-Related Issues and their Impact on Peer Worker Wellbeing

As discussed above, peer work intentions to remain working in the sector are high (88%), yet a significant number of peer workers face stigma and discrimination (42%) and lack of inclusion in the workplace (37%). Of the 6 peer workers currently working but with intentions to resign, 4 responses cited negative or harmful experiences in the workplaces compared with 2 responses (other reasons). In order to understand the extent to which peer workers' wellbeing needs are being met within workplaces, we asked whether challenges at work had ever caused them to take time off work or resign from a peer work role.

The majority of respondents (57%) had taken time off and/or resigned from the role as a peer worker for work-related reasons, with 33% having taking time off work and 24% (around 1 in 4) having resigned from a peer work role for work-related reasons. Of these, peer workers were further asked to describe the challenges that had led to their absence or resignation from work with 78% (29) responding to this question. Examples provided for intentions to leave were lack of supervision and support, and ongoing stigma and exclusion at work.

When comments for reasons absence or resignation were thematically coded, 78% (38 of 49 reasons provided) involve issues related to peer workers not feeling valued, understood or supported by the

organisation and thus fall within the domain of peer workforce management issues. This compares with only 14% relating to critical incident or incident trauma.

The most common reasons provided relate closely to peer workforce readiness on the part of the organisation:

- 12 reported bullying in the workplace, some on multiple occasions within the same or different organisations;
- 11 did not feel they had adequate support and/or supervision in the role;
- 5 reported that they did not feel they were valued as a peer worker;
- 10 reported organisational issues that signal low readiness for peer workforce, including: senior management unsupportive of peer work; organisations not working in the interests of consumers; lack of peer workforce recruitment policy; poor communication in the workplace; organisation did not follow worker's compensation procedures for mental health issues; poor implementation of staff grievance procedures; lack of workplace wellbeing supports; culture averse to communication and feedback to resolve issues promptly.

Less common reasons were:

- Serious critical incident (5 reports);
- Emotionally impacted by client's trauma (2);
- Unethical behaviours in the workplace (2 reports);
- Workload challenges (1 report);
- Dissatisfaction with organisational changes or decisions (1 report).

A sample of responses below highlight how peer workers perceive bullying, mental health stigma and discrimination as intersecting problems within the workplace:

> *I would like to see a Peer Support Worker's Union. Previously unions have not adequately supported me with aforementioned issues that have arisen-citing that there is no legal precedent to advocate for workers with lived experience being discriminated against in the workplace*

I was told I couldn't apply for other positions [within the organisation] because I'm just a peer worker.

I was told by a manager that my diagnosis is incorrect and I should go back on my medication.

I was told I was a "liability" after requesting extra workplace counselling (EAP sessions) because I was triggered in work training.

I felt a lack of understanding and support around my role and my issues as a carer.

I was being used, working freely as a volunteer peer, being unpaid, exploited and expected to take on more responsibilities…

I have been in a workplace and observed…a level of disempowerment [of peer workers] within the NGO you could say bullying.

Stigma, misunderstanding of role, being undervalued, bullying.

I was told by my manager not to attend a meeting that others wanted me to be involved in… Complaints about bullying/barriers to completing my role were deemed "completed and resolved" even after still not having a meeting to discuss the issue.

Bullying! Found this to be the case in many workplaces and for many other people. I put this down to fear, lack of understanding or wanting to embrace peer workers and organisational culture being 'stuck'.

"any concerns or issues you have as a worker are often over emphasised as you "becoming unwell" or "not being up for the job".

Bullying, stigma and discrimination were revealed in this Study as common experiences within the workplace. Peer workers do not have the same level of occupational representation that more established workforces do and bring experiences to workplaces that have traditionally been seen as undesirable, problematic or risky from a human resource management perspective. There is a need for government and employers to support additional safeguarding mechanisms for safety and equality of peer workers in the workplace, described within the report recommendations.

Peer Worker Preferences for Workplace Wellbeing Strategies

Peer workers were asked to rate workplace strategies according their degree of importance to them personally in reducing distress and distress-related absence. Participants could rate this as not important to very important. The majority of peer workers rated every specified item as important for their wellbeing. Table 7 outlines rankings for workplace strategies from highest to lowest importance and indicates initiatives that could improve wellbeing in the workplace. To overcome variation in peer workers' access to these within the workplace, three main areas of activity are required:

Table 7. Importance of Workplace Wellbeing Strategies

Wellbeing Strategies	Important or Very Important (%)	Very Important (%)
Understanding and supportive manager	100	86
Eliminating stigma and discrimination	100	80
Staff understanding and valuing the peer role	98	83
Opportunities to practice self-care in the workplace	98	60
Regular role supervision and guidance	98	53
Return to work support options explained and provided	98	47
Flexible arrangements e.g. shorter days, change in hours, work from home	96	55
Access to advice on rights at work	94	42
Having other peer work colleagues in the workplace	92	50
Employer-employee agreed personal wellbeing plan	80	39
Access to an independent support person when meeting with the employer	70	35
Manager being a peer worker	66	28

Guidance to Employers on Peer Workforce Hire and Retention

Both the peer worker and service provider versions of the survey asked respondents for advice and suggestions to managers on peer workforce hire and retention, as well as general comments about the

peer workforce. Service providers were also asked to provide advice or suggestions on planning and preparing for the peer workforce.

While the views and perspectives about peer workforce retention and management captured by survey do not provide in-depth, rich analysis as would arise through small scale qualitative research, they provide a useful overview of Western Australian peer employer and employee views and needs to inform good industry practice, and which can be supplemented by other available peer work literature. Feedback and advice was similar between peer workers and service providers completing the survey, likely because only providers who had an established peer workforce felt able to provide this advice and therefore those that responded had already acquired good working knowledge of peer worker requirements. Key themes of advice were also similar across the advice provided on hire and retention, and planning and preparation, and are summarised below.

1. Get On Board

Recognise peer workforce hire and integration as a valuable, worthwhile and achievable change within the organisation.

"Don't be afraid", "There is immense value in it", "Do it!","it's well worth it", "do it as soon as possible".

2. Put Supervision and Supports in Place

Ensure adequate supervision and support arrangements tailored to peer worker needs.

> *"Provide them with a lot of support but also with the respect that they have something valuable to contribute just like any other employee."*

3. Become an inclusive organisation.

Commit to and practice equality, inclusion and valuing of lived experience within the workplace.

> *"Peer workers are like any other worker...they can have a wealth of skills other than just their lived experience, so be open for them to make a contribution in whatever way they find meaningful that is within their job description."*

4. **Prepare a welcoming culture prior to employment.**

Recognise the cultural changes involved and prepare the organisation to make critical cultural changes before establishing the peer workforce (e.g. staff education and establishment of adequate HR policies, processes and supports)

> *"Be patient whilst they are learning and asking a lot of questions about how everything works. Make sure that their work colleagues understand their roles and that they also understand the boundaries of their work"*

5. **Stay up to date with good practice.**

Understand and implement industry good practice in peer work, including systems and processes for workforce recruitment and management.

> *"Make sure that there are correct policies and procedures which are aligned to protect both the employer and employee in regards to disability, health and mental health act etc. Put in place an adequate induction program for the peer worker e.g. being buddied up with another peer worker."*

6. **Recruit the right peers for the people your organisation works with, even if it means doing things differently.**

Understand the peer identity, role requirements and team relationships needed to be an effective peer to those who are using the service, and tailor role design, recruitment choices, entry pathways and management arrangements to meet these needs.

> *"The target group [who is a peer] needs to be clearly defined. If (for example) you are recruiting a committee to inform policy around drug treatment, then your peer/consumer reps must be people who have experience of engaging in drug treatment."*

Limitations of the Study

As discussed in the Report Section on Demand Versus Growth, our Report provides a first estimate of peer workforce demand from the perspectives of individuals, families and carers that is highly promising, with 83% of people reporting they would find it helpful in their current situation to talk to someone who has had a similar experience. This is based on a limited size sample (n=39). Larger population sampling is needed for development of state-wide workforce targets and this has been included as a recommendation within the report.

Due to the limited size of the peer workforce, which is reflected in overall sample size, differences between types of peer workers could not be examined, such as differences in employment status, workforce satisfaction between mental health and alcohol and other drug peer workers, between consumer or carer peer workers, and between types of peer roles. The Study was not a Census as it sought current and prior worker profiles from peer workers (e.g. types of role and sector worked in) rather than moment-in-time data about current workforce positions. As such, although the role profiles gathered from peer suggest a greater number of mental health consumer peer work roles than carer/family and alcohol and other drug peer work roles, the number of current positions and distribution of positions cannot be confirmed from the Study.

Overall, peer workers were better represented in this survey than managers, consumers, families and carers, when the sample size is compared to overall population size of these groups. Lower participation rates of consumers, families, carers and service providers may have occurred for a number of reasons but are also consistent with findings of this report- that it is not perceived as a sufficient priority across the sector and that there is a need to support greater awareness and understanding of peer support in order for individuals, families and carers to contribute to peer workforce consultation, design and planning in future.

Summary Findings

Peer Workforce Demand, Supply, Uptake and Barriers and Enablers for Growth

Peer Work is a desired and beneficial support option. Around 9 in 10 of individuals, families and carers surveyed reported they would peer support would benefit them and also supported having choice of access to a peer worker in services. While broader surveying of participants is required to confirm extent of demand, the results indicate that there are insufficient peer workers compared to the number of individuals, families and carers who would benefit from peer options within mental health and alcohol and other drug services. Based on manager and peer worker responses to the survey, there is no evidence that the peer workforce is expanding to meet participant needs. There is a need to improve ease of access to peer workers and peer support options, and a need to grow awareness and understanding of peer work roles among individuals, families and carers.

Peer workforce growth can be constrained by worker supply, job shortages or lack of demand. As will be discussed in the Sustainability section of this report, there are a shortage of peer work jobs relative to supply of workers. While acknowledging that peer workforce growth relies on ongoing supply of peer workers, and development of equivalent vocational training pathways across the mental health and alcohol and other drug sectors, job shortages are the most critical factor underpinning lack of peer workforce growth. Mismatch between demand, supply and uptake of peer work highlights the importance of targets and strategies for peer workforce growth, for monitoring the numbers of peer workers in the sector and for gathering evidence-based estimates of future workforce growth requirements.

Services are expected to grow the peer workforce within an overall shortfall of government commitment and investment. All respondents felt that stronger government leadership and commitment would be helpful. To make peer work widely available across the mental health and alcohol and other drug sector, clear government commitment and leadership must be signalled to the sector through policy commitments and strategic commissioning approaches that overcome contractual barriers, introduce funding streams and incentives, and ensure sectoral capacity building mechanisms are sufficient for supply, uptake, retention and quality of the peer workforce.

Peer Workforce Benefits

83% of individuals, families and carers who had accessed a peer worker reported positive experiences. Individuals, families and carers want to access peer support to enhance service navigation, problem-solving, goal achievement, self-advocacy and self-worth, and benefit from the non-judgmental listening, empathy and sharing of life experiences from someone who has been in a similar situation. When asked to identify which peer workforce benefits were relevant to their service, improved person-centred care, recovery and wellbeing outcomes and lived experience understanding were particularly important.

Workforce Sustainability: Satisfaction, Retention and Wellbeing

75%, or 3 in 4 peer workers, reported feeling satisfied in the workplace overall. Peer work provides a greatly fulfilling vocation and is a highly promising strategy for enhancing wellbeing outcomes for individuals, families and carers. This potential is not currently utilised with poor job vacancies, remuneration issues and poor career pathways for peer workers. Although rates of overall satisfaction were high the majority of peer workers were dissatisfied with job opportunities, career pathways and access to a fair wage.

Peer workers are exposed to significant psychosocial health and safety risks in the workplace. 42% were dissatisfied with levels of stigma and discrimination in the workplace, a majority had taken sick leave for work-related reasons, and 1 in 5 had resigned for work-related reasons. The majority of (78%) of work-related reasons are attributable to peer workforce management problems, such as lack of role understanding, lack of executive support, poor supervision and lack of tailored/inclusive policies. Disturbingly frequent experiences of stigma, discrimination and bullying in the workplace highlight the need for immediate attention to and improvement of peer workplaces to support the health, wellbeing and retention of peer workers. Peer workers do not have the same level of occupational representation that more established workforces do and bring experiences to workplaces that have traditionally been seen as undesirable, problematic or risky from a human resource management perspective. There is a need for government and employers to support additional safeguarding mechanisms for safety and equality of peer workers in the workplace, described within the report recommendations.

Conclusion

This Report finds that peer work carries extensive benefits for, and has substantial support from individuals, families and services, yet there is no demonstrable peer workforce growth in Western Australia. There is an urgent need for strengthened policy commitments, growth targets and strategies, tied to commissioning for peer work and greater support for essential capacity building and safeguarding arrangements for peer workforce safety, equality and retention in the workplace.

Strategic, coordinated and proactive commitment is needed across all stakeholders (governments, service providers, workforce industry bodies, peer workers, and consumers and family representative and advocacy groups) to fully establish peer work as a core workforce in the mental health and alcohol and other drug sectors. Recommendations from this Report offer a suite of nine areas of action for jointly progressing the peer workforce in Western Australia, including recommendations for employers, policy makers and commissioners.

Recommendations

***Recommendations 1, 2, 8 and 9 are classified as recommendations for immediate action.**

1 Service Uptake to Meet Local Needs

Mental health and alcohol and other drug services should identify and remove barriers to individuals, family member and carer access to peer workers, through appropriate strategies to grow peer workers and peer support programs.

2 System-Wide Growth Strategy and Targets

2.1 Commissioners and policy makers should set assertive growth targets, target monitoring arrangements, and workforce strategies to support growth and development of peer workforce and peer support programs. This includes policy makers with responsibilities for overseeing or guiding part or all of the mental health and/or alcohol and other drug sector in Western Australia, including regional, state and national policy makers with responsibilities for the private, public, community, primary care and NDIS sectors.

2.2 While the setting of growth targets is an immediate priority, further workforce targets should be evidence-based and gathered through direct, broad-based and representative sampling of people accessing mental health and alcohol and other drug services, including controlling for awareness barriers that may lead to under-estimation of demand.

3.Tracking Peer Workforce Growth

To achieve strategic targets (Recommendation 2), there is a need for investment in a system for monitoring WA mental health and alcohol and other drug peer workforce uptake and distribution across settings and funding streams. It is recommended for cost effectiveness that this occur through funding of a WA peer workforce census every 2 years to map peer workforce availability, employment conditions and job prospects across settings.

4.Awareness, Education and Navigation

System-wide and service provider strategies to grow the peer workforce (Recommendations 1 & 2) should include mechanisms to inform, educate and facilitate navigation and access to peer by individuals, families and carers.

5. Outcomes Evaluation

System-wide and service provider strategies to grow the peer workforce (Recommendations 1 & 2) should include mechanisms to capture and collaboratively share the distinct contribution made by peer work to individual, family member and carer outcomes. Peer workforce evaluation should include participant outcomes and secondary benefits- improvements to service cultures and service delivery approaches- that indirectly enhance participant outcomes.

6. Policy Leadership and Commitment

Peer workers and peer support approaches should be included on an ongoing basis across all strategies, policies and plans that relate to the growth, availability or quality of mental health and/or alcohol and other drug services.

7. Dual Qualifications Pathways

Training (pre-Cert IV and Cert IV) options should be developed and resourced to provide for equal peer worker opportunities and capabilities for peer work across the mental health and alcohol and other drug sector. Co-occurring experiences are the norm, rather than exception but there are limited training pathways to acquire alcohol and other drug peer work competencies and no qualifications for integrated mental health and alcohol and other drug peer work.

8. Commissioning Leadership

Commissioning strategies to support achievement of peer workforce targets and strategies should be designed and implemented, including:

- Identifying and overcoming existing contractual barriers raised by providers in this Study;
- Incorporating peer workforce models and targets into the purchasing of future mental health and alcohol and other drug services;
- Grants assistance for workforce establishment, and;
- Provision for adequate mechanisms for occupational safety, representation and development (see Recommendations 8.1-8.4);

9.Occupational Safety, Representation and Development

Peer workers are not yet collectively represented to the same level as other health occupations but face unique and significant workplace risks and improved occupational safety and representation mechanisms are required. To eliminate and prevent psychosocial hazards, stigma and discrimination against peer workers in the workplace it is critically important that:

9.1 Peer workers are supported in their right to lead development of their occupation and to represent their occupation within the sector, through adequate and sustained investment in peer work groups/associations.

9.2 There is adequate and sustained investment in peer workers developing employer standards, advice, resources and training on occupational inclusion and equal opportunity for employers.

9.3 Peer Workforce Employer Standards, once developed form part of the framework of quality standards that are used to assess mental health and alcohol and other drug services in Western Australia.

9.4 There is adequate and sustained investment in supports for peer workers external to (independent from) services, including information, advice and support (such as access to an employee support person) on resolving work-related concerns such as bullying, stigma and discrimination.

9.5 Employers should proactively respond to employee safety, equality and satisfaction issues identified in this report through:

- Ascertaining the extent to which these industry-wide issues are occurring within their own services through peer worker consultation;
- Fostering ongoing collaborative and consultative relationships to enable peer worker concerns to be raised and addressed. Employers should support peer workers to access union and peer worker representation within these consultative processes;
- Ensuring that all employees and managers in the workplace understand and demonstrate peer work inclusion as a core requirement of the workplace;
- Ensuring a peer inclusive organisation through utilising consumer, family member and carer expertise and leadership (peer workers) in the governance, management and evaluation, as well as delivery, of services, and ensuring mutually supportive relationships are fostered between peer workers contributing across these aspects of the organisation;
- Ensuring peer supervision (supervision by an experienced peer worker) and opportunities to connect with other peer workers are made available to peer workers on an ongoing basis in addition to line management supervision, for professional development, employee wellbeing, and for prevention and timely resolution of issues in the workplace;
- Reviewing fair remuneration arrangements and adjusting if required, through external benchmarking of peer roles against other peer roles in the industry and/or internal benchmarking against non-peer roles requiring similar levels (albeit different kinds) of competency and responsibility.
- Maintaining industry networks and links to stay current with peer workforce standards and best practice in the industry.

Next Steps for Employers

Develop and Grow the Peer Workforce

Identify and remove barriers to individuals, family member and carer access to peer workers, through appropriate strategies to grow peer workers and peer support programs.

Promote and Facilitate Access

Develop ways for your service to better inform, educate and facilitate navigation and access to peer workers and peer support options by individuals, families and carers.

Capture and Share the Benefits

Find ways to capture the benefits (outcomes) of peer work within your service and to share this with the broader sector. This should include benefits to individuals, families and carers and secondary benefits- improvements to services - that indirectly benefit people.

Understand and Address Safety and Wellbeing Risks at Work

Proactively respond to the unique risks and issues peer workers face in workplace through:

- Ascertaining the extent to which these industry-wide issues are occurring within your service through peer worker consultation (e.g. stigma, discrimination, bullying, exclusion);
- Fostering ongoing collaborative and consultative relationships to enable peer worker concerns to be raised and addressed. Support peer workers to access union and peer worker representation within these consultative processes;
- Ensuring that all employees and managers in the workplace understand and demonstrate peer work inclusion as a core requirement of the workplace;
- Ensuring a peer inclusive organisation through utilising consumer, family member and carer expertise and leadership (peer workers) in the governance, management and evaluation, as well as delivery, of services, and ensuring mutually supportive relationships are fostered between peer workers contributing across these aspects of the organisation;
- Ensuring peer supervision (supervision by an experienced peer worker) and opportunities to connect with other peer workers are made available to peer workers on an ongoing basis in addition to line management supervision, for professional development, employee wellbeing and prevention and timely resolution of issues in the workplace;
- Reviewing fair remuneration arrangements and adjusting if required, through external benchmarking against other peer and/or non-peer roles at similar levels of competency.
- Maintaining industry networks and links to stay current with peer workforce standards and best practice in the industry.

Next Steps for Policy Makers and Commissioners

The following suite of recommendations are those specifically for policy makers and commissioners with responsibilities for overseeing, guiding or commissioning part or all of the mental health and/or alcohol and other drug sector in Western Australia, including regional, state and national policy makers with responsibilities for the private, public, community, primary care and NDIS sectors.

***Recommendations 2, 8 and 9 are classified as recommendations for immediate action.**

2 System-Wide Growth Strategy and Targets

2.1 Set assertive growth targets, target monitoring arrangements, and workforce strategies to support growth and development of peer workforce and peer support programs.

2.2 While the setting of growth targets is an immediate priority, set further workforce targets that are evidence-based through direct, broad-based and representative sampling of people accessing mental health and alcohol and other drug services, including controlling for awareness barriers that may lead to under-estimation of demand.

3.Tracking Peer Workforce Growth

To achieve strategic targets (Recommendation 2), invest in a system for monitoring WA mental health and alcohol and other drug peer workforce uptake and distribution across settings and funding streams. It is recommended for cost effectiveness that this occur through funding and support for a WA peer workforce census every 2 years to map peer workforce availability, employment conditions and job prospects across settings.

4.Awareness, Education and Navigation

In developing peer workforce strategies, include mechanisms to inform, educate and facilitate navigation and access to peer by individuals, families and carers.

5. Outcomes Evaluation

In developing peer workforce strategies, include mechanisms to capture and collaboratively share the distinct contribution made by peer work to individual, family member and carer outcomes. Peer workforce evaluation should include participant outcomes and secondary benefits- improvements to service cultures and service delivery approaches- that indirectly enhance participant outcomes.

6. Policy Leadership and Commitment

Include peer workers and peer support approaches across all strategies, policies and plans relating to the mental health and/or alcohol and other drug sector

7. Dual Qualifications Pathways

Develop training (pre-Cert IV and Cert IV) options that provides for equal peer worker opportunities and capabilities for peer work across mental health and/or alcohol and other drugs sector. Co-occurring experiences are the norm, rather than exception but there are limited training pathways to acquire alcohol and other drug peer work competencies and no qualifications for integrated mental health and alcohol and other drug peer work.

8. Commissioning Leadership

Develop and implement commissioning strategies to support achievement of peer workforce targets and strategies, including:

- Identifying and overcoming existing contract barriers raised by providers in this Study;
- Incorporating peer workforce models and targets into future service grants and tenders;
- Grants assistance for workforce establishment, and;
- Provision for adequate mechanisms for occupational safety, representation and development (see Recommendations 9.1-9.4);

9.Occupational Safety, Representation and Development

To eliminate and prevent psychosocial hazards, stigma and discrimination against peer workers in the workplace,

9.1 Support peer workers in their right to lead development of and represent their occupation within the sector, through support and investment in peer work groups/associations.

9.2 Provide for adequate and sustained investment in peer workers developing standards, advice, resources and training for employers on peer work inclusion and equal opportunity. This should include development of Peer Workforce Employer Standards.

9.3 Include future Peer Workforce Employer Standards with the framework of quality standards used to assess mental health and/or alcohol and other drug services in Western Australia.

9.4 Provide for adequate and sustained investment in supports for peer workers external to (independent from) services, including information, advice and support (such as access to an employee support person) on resolving work-related concerns such as bullying, stigma and discrimination.

References

[1] See, for example, Flourish (formerly Richmond PRA). 2013. Policy Direction Paper. Embracing Inclusion: Employment of People with Lived Experience. Retrieved from: https://www.flourishaustralia.org.au/sites/default/files/news_publications/Embracing%20Inclusion%20-%20Lived%20Experience%20-%20Final%20v3.1%20-%20Web.pdf

[2] Centre for Mental Health. 2013. *Peer support in mental health care:is it good value for money?* Retrieved from: http://eprints.lse.ac.uk/60793/

[3] Inspire Foundation. 2014. CrossRoads: Rethinking the Australian Mental Health System. Retrieved from: http://about.au.reachout.com/wp-content/uploads/2015/01/ReachOut.com-Crossroads-Report-2014.pdf

[4] Scanlan, J., N. Hancock & A. Honey. 2017. Evaluation of a peer-delivered tranisitional and post-discharge support program following psychiatric hospitalisation. *BMC Psychiatry.* 17:307.

[5] Davidson, L. et al. 2012. *Mental Health Policy Paper: Peer Support Among People With Severe Mental Illnesses; A Review of Evidence and Experience. World Psychiatry 2012;11:123-128*

[6] Chinman, M. et al. 2014. *Peer Support Services for Individuals With Serious Mental Illnesses: Assessing the Evidence.* Psychiatric Services. 65(4): 429-441.

[7] Repper, J. & T. Carter. 2011. A Review of the Literature on Peer Support in Mental Health Services. Journal of Mental Health, 20(4): 392–411

[8] Reif S., Braude L., Lyman R. et al. 2014. Peer recovery support for individuals with substance use disorders: assessing the evidence. *Psychiatric Services.* 65(7), p. 853–861.

[9] Lawn, S., A. Smith & K. Hunter. 2008. Mental Health Peer Support for Hospital Avoidance and Early Discharge: An Australian Example of a Consumer Driven and Operated Service. *Journal of Mental Health.* 17(5): 498-508.

[10] See Libby Gawith and Pam Glover. 2009. An Evaluation of Comcare's Warmline. http://www.warmline.org.nz/whatiswarmline.html. See also Planning Council for Health and Human Services. 2010. Warmline, Inc.: A Description of Services, Caller Voices, and Community Perspectives.

[11] Melbourne Social Equity Institute. 2014. Seclusion and Restraint Project Report Prepared for the National Mental Health Commission. http://socialequity.unimelb.edu.au/__data/assets/pdf_file/0017/2004722/Seclusion-and-Restraint-report.PDF

[12] Ashcraft, L. & W. Anthony. 2008. Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services. Psychiatric Services. 59(10):

[13] Institute of Mental Health and Nottinghamshire Healthcare NHS Trust. N.d. *Transforming the Culture of Mental Health Services Through Peer Support: Learnings from the Project.* Retrieved from: http://www.health.org.uk/sites/health/files/TransformingCultureMentalHealthServicesPeerSupport.pdf

[14] Health Workforce Australia. 2014. *Mental Health Peer Workforce Study.* Adelaide SA: Health Workforce Australia.

[15] Mental Health Commission of Western Australia. 2015. *Better Choices, Better Lives,* the WA Mental Health, Alcohol and Other Drug Services Plan 2015-2015. Perth, Western Australian Mental Health Commission, pp.154,181.

[16] Mental Health Commission of Western Australia. 2018. Strategies in Development. https://www.mhc.wa.gov.au/about-us/strategic-direction/strategies-in-development/

[17] National Mental Health Commission. 2014. *Contributing Lives, Thriving Communities: Report of the National Review of Mental Health Programmes and Services. Volume 1: Strategic Directions, Practical Solutions 1-2 years, p. 120.*

[18] Department of Health. 2017. The Fifth National Mental Health and Suicide Prevention Plan. http://apo.org.au/system/files/114356/apo-nid114356-451131.pdf pp.46-47.

[19] ibid

[20] Intergovernment Committee on Drugs. National Alcohol and Other Drug Workforce Development Strategy 2015-2018. pp21-22. http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/C8000B21B6941A46CA257EAC001D266E/$File/National%20Alcohol%20and%20Other%20Drug%20Workforce%20Development%20Strategy%202015-2018.pdf

[21] Department of Health. 2017. National Drug Strategy 2017-2026. Commonwealth of Australia: Canberra.

[22] Australian Institute of Health and Welfare. *Workforce: Health Workforce*. Retrieved from http://www.aihw.gov.au/workforce/

[23] National Disability Services. July 2017. *Australian Disability Workforce Report- First Edition Released*. https://www.nds.org.au/news/australian-disability-workforce-report-first-edition-released

[24] Mental Health Commission of Western Australia. 2014. Western Australian Non-Government Organisation Establishment In Brief: 2013-14. Retrieved from: https://www.mhc.wa.gov.au/media/1608/western-australian-non-government-organisation-_establishment-_-in-brief-2013-14-2.pdf

[25] Australian Institute of Health and Welfare. 2014-15. Specialised Mental Health Care Facilities: Table FAC.34. Retrieved from: https://mhsa.aihw.gov.au/resources/facilities/staffing/

[26] National Research Centre on Alcohol and Other Drugs Workforce Development. 2010. Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene. Retrieved from: http://nceta.flinders.edu.au/files/4912/7200/2031/EN422_Roche_Pidd_2010.pdf

[27] Western Australian Network of Alcohol and other Drug Agencies (WANADA) (2017). Comprehensive Alcohol and other Drug Workforce Development in Western Australia. Western Australian Network of Alcohol and other Drug Agencies (WANADA), Perth, p.87.

[28] Id, p.70

[29] Ridoutt, L., Pilbeam, V. and Perkins, D. (2014). Final report on workforce requirements in support of the 2014 National Review of Mental Health Programs and Services, National Mental Health Commission, p.52 and 72.

[30] Ibid

[31] WAAMH. 2014. Peer Work Strategic Framework. P.12. Retrieved from: https://waamh.org.au/assets/documents/projects/peer-work-strategic-framework-report-final-october-2014.pdf

[32] Fair Work Australia. 2017. Fact Sheet: workplace Discrimination. Retrieved from: https://www.fairwork.gov.au/how-we-will-help/templates-and-guides/fact-sheets/rights-and-obligations/workplace-discrimination