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Psychosocial Hazards in the Lived Experience (Peer) Workforce

PROJECT REPORT

MHLEPQ
MENTAL HEALTH LIVED EXPERIENCE PEAK QUEENSLAND

Queensland Lived Experience Workforce Network

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Glossary

TERM	DESCRIPTION
Burnout	A constellation of symptoms—malaise, fatigue, frustration, cynicism, and inefficacy—that arise from "making excessive demands on energy, strength, or resources" in the workplace.
Consumer perspective	Personal experience of mental health challenges, service use and periods of healing/personal recovery [ix].
Designated Lived Experience (Peer) role	Designated Lived Experience (Peer) role indicates a role which makes lived experience expertise an essential requirement in addition to the relevant practices, skills and knowledge and the Peer work values needed for the role.
Discipline specific supervision	Discipline specific supervision, focuses on reflective practice, the impact of the [individual's] work, debriefing, and the application of a worker's unique skills and lived experience in their working environment [x]
EAP	Employer Assistance Program. EAPs are offered by employers to support their employees' mental health, emotional well-being, and overall productivity.
Emotional Labour	Emotional Labour is displaying certain emotions to meet the requirements of a job. The term emotional labour originated from the research of Hochschild (1979, 1983). She distinguished between emotional work (managing and regulating feelings in the private sphere) and emotional labour (an occupational expectation of service workers).
Epistemic injustice	Epistemic injustice is injustice related to knowledge. It includes exclusion and silencing; systematic distortion or misrepresentation of one's meanings or contributions; undervaluing of one's status or standing in communicative practices; unfair distinctions in authority; and unwarranted distrust [viii].
Epistemology	Epistemology is the theory of knowledge. It is concerned with the mind's relation to reality.

Gender discrimination	Gender discrimination is when someone is treated unequally and unfairly based on their gender identity. Like all discrimination, gender discrimination is a human rights violation.
Lateral violence	Lateral violence is attack or undermine another individual or group. It may be sustained attacks on individuals, families, or groups [ii]. Lateral violence undermines cultural safety and trust and increases the isolation of targeted people. Behaviours may include can be gossiping, put-downs, bullying, shaming, or social exclusion [ii].
Line Management	Line management is generally responsible for the oversight and guidance of the direct operational activities of the staff member. This includes workloads, allocation of tasks, contracts, leave, human resource issues, performance development and the overseeing of compliance with policy and targets.[x]
Lived Experience (capitalised)	Experiences of life-changing mental health challenges, service use and periods of healing that have profoundly impacted a person's worldview; direction; and life as they knew it. This can be a direct personal (consumer) experience or an experience as a family member/carer supporting a loved one facing mental health challenges.
Lived Experience (Peer) workforce	Lived Experience workforce is a collective term used to refer to both the personal (consumer) workforce and family/carer (support) workforce. They are people employed in identified Lived Experience roles to assist others by applying what they have learned from their direct personal experience or experience of supporting someone through mental health challenges, service use and recovery[i].
Moral Distress/Injury	Moral injury refers to the psychological, social, and spiritual impact of events involving betrayal or transgression of one's own deeply held moral beliefs and values, often occurring in high stakes situations. Moral injury occurs when we perpetrate, bear witness to, or fail to prevent an act that

	transgresses our deeply held moral beliefs[ix]. Moral distress is the emotional state that give rise to the injury and may occur when a person feels ethically compromised in the course of their work or are required to act in a manner contrary to personal and professional values, which undermines personal integrity and authenticity.
Organisational justice	Organisational justice is the extent to which an organisation treats people fairly. Organisational justice includes fairness related to outcomes, procedures, and interpersonal interactions.
Paternalistic	Action limiting a person's or group's liberty or autonomy yet intended to promote their own good.
Psychosocial Hazard	A psychosocial hazard is a hazard that arises from, or relates to, the design or management of work, a work environment, plant at a workplace, or workplace interactions and behaviours. These hazards may cause psychological harm, whether they also cause physical harm, or not. In severe cases exposure to psychosocial hazards can lead to death by suicide[iii].
Resilience	Resilience is the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands.
Survivor Standpoint Epistemology	Survivor Standpoint Epistemology is a theory proposing that authority is rooted in individuals' personal knowledge and perspectives and the power that such authority exerts. It is a theory for analysing experiential sharing that occurs among participants and emphasizes the everyday experiential, concept of knowing (i.e., epistemology). The theory emerged from the argument that people from an oppressed class have special access to knowledge that is not available to those from a privileged class. The theory:

	• denies that traditional science is objective and suggests that research and theory have ignored and marginalized survivor's ways of thinking. • suggests that an individual's perspectives are shaped by their social and political experiences, and the amalgamation of a person's experiences forms a standpoint—a point of view—through which that individual sees and understands the world[iv].
Systemic bias	Systemic bias is the innate tendency of a process to support particular outcomes, and in human systems such as institutions, advantage one group over another.
Vertical Violence	Vertical violence is a type of workplace violence that occurs between colleagues in different hierarchical positions, i.e., superiors and subordinates. It is particularly prevalent in the healthcare sector, where gender and professional hierarchies can often exacerbate its impact[v].
Vicarious Trauma	The transformation of the helper's inner experience as a result of empathetic engagement with a survivor and their trauma. Simply put, when we open our hearts to hear someone's story of devastation or betrayal, our cherished beliefs are challenged, and we are changed[iv].

Terminology

Throughout this report we have used the term Lived Experience Worker and Peer Worker interchangeably. We acknowledge the ongoing challenge with the inconsistency of terminology across the sector and how this can lead to confusion for our Lived Experience workforce, as well as the difficult implications this creates for legislation, policy, and practice.

The term 'Lived Experience (Peer) Workforce' has been adopted from national research which informed the development of the 2021 National Lived Experience (Peer) Workforce Development Guidelines. Rather than being understood as limited to a direct consumer support role, the contemporary language shifts the focus to reflect the range of roles within the workforces.

Acknowledgements

We acknowledge and pay respect to Aboriginal and Torres Strait Islander peoples as the traditional custodians of the land and waters on which we live, work and play. We recognise that sovereignty was never seceded and that the ongoing impacts of intergenerational trauma take time, compassion, and hard work to heal.

We would like to thank the project partner organisations Mental Health Lived Experience Peak Queensland (MHLEPQ) and Queensland Lived Experience Workforce Network (QLEWN), members of the project team including the Project Partnership Overseeing Committee and Project Advisory Committee, and all Lived Experience (Peer) workers who contributed to the consultations through attending focus groups and completing the statewide online survey. Without your courage in sharing your Lived Experience of your role as a Lived Experience (Peer) Worker, this work could not have happened, thank you.

Recommendations

This report has produced seven recommendations for workplaces to consider in managing psychosocial hazards. Each recommendation is based in the lived experience of Peer workers with exposure to psychosocial hazards.

1. Organisations engaging Peer workers should conduct a Peer-worker resourcing assessment to ensure Peer workers have adequate career and training opportunities and are adequately resourced for the work assigned to them.

2. Organisations employing Peer workers should ensure appropriate peer-based supervisory structures are in place. This goes beyond professional supervision to including operational supervision so Peer workers can seek managerial advice from a suitably qualified person (a Peer worker).

3. Workplaces engaging Peer workers should conduct mandatory training for all staff (including clinical staff) to ensure they are educated and understand the role and practice framework of Peer workers in the workplace.

4. Employers engaging Peer workers should ensure ongoing training and development opportunities are afforded to the Peer workforce relevant to the skills and expertise utilised by the Peer workers.

5. Employers engaging a Peer workforce should ensure lived experience is represented at all levels of the organisation. Organisations should audit practices to ensure gender discrimination in recruitment does not exist, so systemic bias does not replicate itself.

6. Employers should monitor workplace culture closely with particular focus on interdisciplinary engagements and hierarchical barriers to collaboration.

7. Ensure that workplace rules are applied fairly, consistently and in an unbiased manner. Ensure there is a transparent grievance and appeal process, promote and encourage a positive and fair work environment.

Introduction

The Psychosocial Hazards in the Lived Experience (Peer) Workforce project (the Project) has identified unique workplace psychosocial hazards of the Mental Health and Suicidality Lived Experience (Peer) Workforce working in the public and community health system. Findings include solutions for hazard management and better outcomes for Peer workers, proposed by Peer workers.

Hazards include those that are generic to all staff that work in the health system as well as hazards that may be unique to the Lived Experience (Peer) workforce. The focus of the project was systemic deficits and solutions, rather than individual ones.

The project centred around two questions:

1. Identify the psychosocial hazards unique to the Lived Experience (Peer) workforce in Queensland? (What are the hazards?)
2. What does the Lived Experience (Peer) Workforce suggest could be done to address the psychosocial hazards in the workplace? (What would help?)

The geographical scope of the work was statewide Queensland, incorporating public mental health sectors from both community and hospital settings. It was specific to Lived Experience (LE) employees that work from a consumer perspective in mental health and suicidality. Participants represented a broad range of priority groups, self-defined in consultation.

This report includes findings from both consultations and will inform the final position paper.

Methodology

This report describes the experiences of Lived Experience (Peer) Workers around psychosocial hazards in the workplace and what could be done to prevent or intervene early to mitigate them. Survivor Standpoint Epistemology (Rose, 2009)[i] was the theoretical framework that informed the methodology.

A Lived Experience Project Partnership Overseeing Committee (PPOC) was formed to provide input and oversee the project, with representatives from the two Lived Experience organisations Mental Health Lived Experience Peak Queensland (MHLEPQ) and Queensland Lived Experience Workforce Network (QLEWN).

Three focus groups and a statewide survey were used to gather data and a thematic analysis was applied to obtain the findings. Themes that emerged from the focus group summaries were provided to the participants for their feedback, further insights, and amendments.

The qualitative inquiry took a trauma-informed, participatory approach to understanding the perspectives of people with lived experience who are members of the Peer workforce (the "insiders"), and their insights into what would support change and improvement in their workplaces.

Recruitment

Project Advisory Committee

An expression of interest for Lived Experience Project Advisory Committee (PAC) members was distributed through the partner organisation membership, on social media, and through known Lived Experience networks. Six responses were received, and a Lived Experience PAC was formed to guide design and implementation of the project. Lived Experience PAC members' backgrounds included Research, Human Resources, and Law, with two PhD candidates, a youth and perinatal perspective. Three worked in health and three worked in community. Remuneration was available for members according to QLEWN sitting fee policy.

Research Participants

Expressions of interest for focus group participants were distributed through the partner organisation membership, on social media, and through known Lived Experience networks. The criteria for attendance were:

1. Over the age of 18, and
2. A current Lived Experience Peer Worker, and
3. Working from a Consumer perspective in mental health/suicidality in Queensland.

Participants were inducted into the group using a collaborative "ways of working" framework and asked to commit to reading related material before the focus group. They were asked to either attend the focus group (in-person, or online) or advise if they were an apology. Participants were also required to seek approval from their employer to attend during work hours, or to attend in their own time.

Consultation

Twenty-one Lived Experience (Peer) Workers from across the state of Queensland were eligible to participate in the three focus groups. Forty-three Lived Experience (Peer) Workers were eligible to complete the online survey. One focus group was held face-to-face while two were held online.

Lived Experience Debriefing

Debriefing is a structured voluntary discussion aimed at putting a challenging event into perspective - it is not counselling. Lived Experienced debriefing is

provided by a trained person who identifies as having a Lived Experience. It offers a person an opportunity to make sense of and find clarity after a difficult experience and assists them to establish a process for recovery.

Lived Experience (Peer) Workforce debriefing was made available to all focus group participants and PAC members, throughout the project. The Project External Lived Experience Debriefer was contracted to provide a free confidential debriefing session at a mutually agreeable time. A total of three Lived Experience Debriefing sessions were provided.

Data Collection and Analysis

Data were collected from focus groups and the online survey and analysed using narrative and thematic methods. Participants who completed the online survey were anonymous. Findings were summarised and discussed in separate reports. The focus group summary was circulated to all focus group participants for feedback and consent to use verbatim quotes. Both the focus group summary and survey summary reports were circulated to the PPOC and PAC members for review.

Methods: Survey

The statewide online survey was available between the 23rd of October and 10th November 2023. The twenty-four survey questions were co designed with the project team. A total of 43 responses were used for this report. A combination of multiple choice and open questions were used. Demographics, and geographical and workplace setting questions were asked to measure diversity of responses, results are in table's 1, 2, and 3.

Methods: Focus groups

Three focus groups were held during October 2023 with a total of twenty-one participants. Focus Group participants went into small groups and were asked, "what are the psychosocial hazards unique to the consumer (Peer) Lived Experience workforce?" Responses were captured and a thematic analysis identified psychosocial hazards similar to the survey participants, listed below.

Findings: Psychosocial Hazards in the Workplace

Survey Results

Lived Experience roles.

Survey participants represented a broad range of Lived Experience roles in the workplace. A compilation of roles as described by the participants can be found in Appendix A.

Demographics

Of the total 43 participants, there were several genders with a majority identifying as female. Ages spanned from 25 to 64 years of age with the largest proportion being between 45 and 54 of age. Participants' ethnicity included two First Nations people, five identifying as migrants, and nine survey participants identified as culturally and linguistically diverse. Eight participants identified as LGBTIQA+ and just over half of all survey participants identified as being a person living with disability (ies) including psychosocial disability.

	Identity	Participant %
Gender	Male	25%
	Female	65%
	Non-Binary	5%
	Prefer not to say	5%
Age	25-34 years of age	14%
	35-44 years of age	16%
	45-54 years of age	47%
	55-64 years of age	23%
Ethnicity	First Nations people.	4%
	Prefer not to say	7%
	Identified as being migrant	12%
	Prefer not to say	5%
	Identified as culturally and linguistically diverse.	21%
	Prefer not to say	7%
Sexuality	Identified as LGBTIQA+	19%
	Prefer not to say	5%
Disability	Identified as being a person living with disability (ies) including psychosocial disability.	51%

Table 1: Survey participants' demographics

Participants were asked where they were located geographically in the state of Queensland with most of all participants in the Brisbane metropolitan area's North and South.

Location	Percentage%
Brisbane North	26%
Brisbane South	26%
Sunshine Coast	16%
Gold Coast	9%
Far North Queensland	7%
Wide Bay	5%
Darling Downs	5%
Mackay, Whitsundays	2%
Central Queensland	2%
Western Queensland	2%

Table 2: Survey participants' geography

Workplace settings

Twenty-one survey participants worked in public health government sector and twenty-one, worked in community non-government sector while one worked in the private sector. 46% were full-time employees, 48% were part-time and 3 were casually employed. The highest number of staff employed in the workplaces of survey participants was 21-50 employees.

	Workplace Setting	Percentage%
Sector	Public Health Government	48%
	Community non-government	48%
	Private	2%
Employed	Full time	47%
	Part Time	47%
	Casual	6%
Number of staff employed in workplace	1-5	5%
	6-10	19%
	11-20	14%
	21-50	28%
	51-100	5%
	Over 100	23%
	Unsure	6%

Table 3: Survey participants' workplace

A majority of participants identified as being a person living with disability (ies) including psychosocial disability (51%) and having or currently experiencing social disadvantage including homelessness and poverty (56%).

The Queensland Work Health and Safety document *Managing the risk of psychosocial hazards at work: Code of Practice (2022)* [iii] (the Code of Practice) lists the most common psychosocial hazards in the workplace and these hazards were reflected in the survey results:

- Lack of role clarity
- Traumatic events or materials
- Poor organisational justice
- Harmful behaviours

Further information about these psychosocial hazards is in Appendix B. It should be noted that while the hazards are generic across all staff in the health systems, the impact of these hazards if unmanaged may not be the same between the general health staff and the Peer workforce.

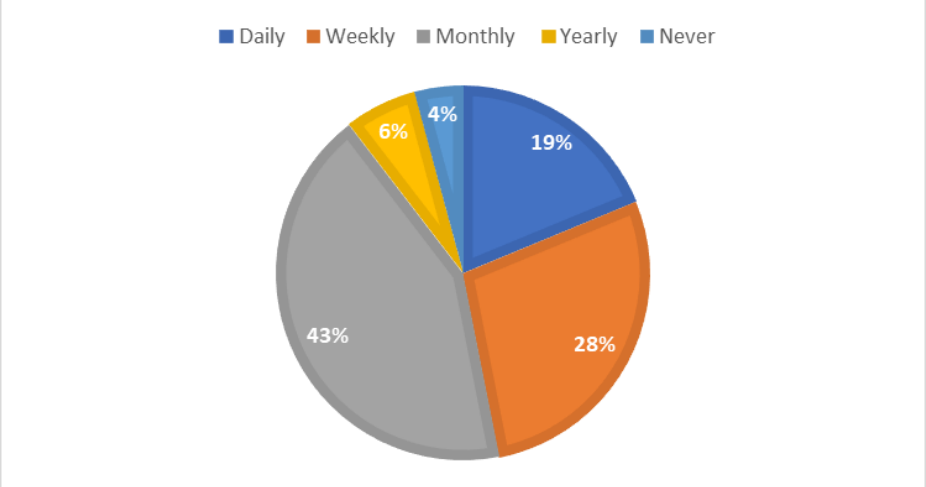
In addition to the common psychosocial hazards, three psychosocial hazards unique to the Lived Experience (Peer) workforce in Queensland were identified in the survey results as:

- Moral distress/injury.
- Disregard of emotional work and labour, and
- Epistemic injustice.

Survey participants were asked which psychosocial hazards in the workplace impacted the most on their mental health and wellbeing and the highest-ranking results were:

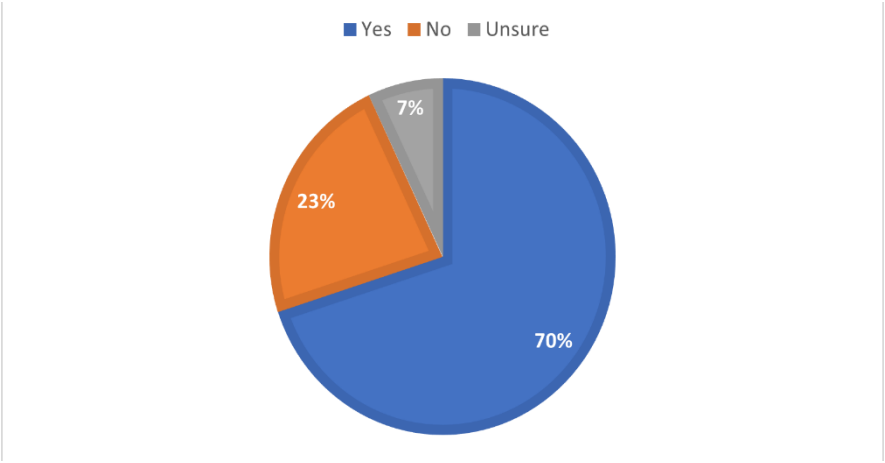
- Moral injury/Values clash.
- Lack of role clarity, and
- Vicarious trauma,

Survey participants were then asked about the frequency of various psychosocial hazards in the workplace. The majority of respondents experienced the most common three hazards at least monthly (43%), weekly (28%) or daily (19%).



Graph 1: Frequency of all psychosocial hazards experienced by Lived Experience (Peer) Workers

An additional question was asked about traumatic events in the workplace. A traumatic event was defined as an incident that caused physical, emotional, spiritual, or psychological harm. Survey participants were asked "As a result of having a Lived Experience have you experienced a traumatic event in the workplace?" Almost 70% of participants had experiences of traumatic events related to their lived experience.



Graph 2: Lived Experience (Peer) Workers experiences of trauma in the workplace.

Impacts of psychosocial hazards when frequent, prolonged, or severe can lead to psychological and physical Harm. Workers are likely to be exposed to a combination of psychosocial hazards; some hazards may be consistently present, while others only occasional.

The survey participants noticed various impacts to their psychological and physical health due to psychosocial hazards. Several survey group participants stated that they have left employment due to the impacts of psychosocial hazards. Participants described the following impacts:

Impacts of psychosocial hazards	Percentage
Increased anxiety	72%
Concentration issues	63%
Sleep issues	58%
Depressed mood	53%
Loss of interest and pleasure	46%
Feeling like I am becoming mentally unwell again	44%
Headaches	42%
Feeling worthless	37%
Poor immune function (getting physically sick more)	25%
Changes in weight	20%
High blood pressure	9%
Prefer not to say	5%
I do not experience work related stress from psychosocial hazards in my workplace	2%

Table 7: Impacts of psychosocial hazards on the Lived Experience (Peer) Workforce

Note. Survey Participants could choose more than one response listed in the above table.

Focus Group results

Findings from the focus groups identified ten psychosocial hazards, three of which were not listed as common hazards in the Code of Practice (in bold).

Psychosocial Hazard	**Identified in the Code of Practice Y/N**
Moral distress	**N**
Disregard of the emotional labour in Lived Experience (Peer) work	**N**
Epistemic Injustice	**N**
Lack of role clarity	Y
Vicarious trauma	Y
Low reward and recognition	Y
Poor organisational justice	Y
High and low workload	Y
Poor support	Y
Poor workplace relationships including interpersonal conflict	Y

Table 5: Psychosocial hazards identified by focus group participants.

During the focus group consultations there were many first-hand experiences of poor practice by non-peer worker staff in the workplace. Vertical and lateral violence, workplace microaggressions, weaponising of Peer worker issues, gaslighting, discrimination, stigma, and disrespectful language. One focus group participant stated, "vulnerability is ripe for exploitation". Witnessing and being the victim of poor practice was described as extremely distressing. For those who had spoken up about poor practice, they found that lack of accountability by those responsible was an added stress (poor organisational justice). There was frustration and feelings of hopelessness due to the inability to change the poor practice of others.

Focus group participants described what psychosocial hazards looked like in practice and how they felt. This is captured in the summary table 6 below:

Psychosocial Hazard	What it looks like in Practice	What it feels like
Moral distress	Paternalism by senior staff Values Clashes. Lack of recognition of the emotional labour of Lived Experience Peer work Witnessing unfair treatment; service users not having a voice, being disregarded. Witnessing challenging professional practice but feeling less able to act due to power dynamics. Being made a part of restrictive practices which go against Peer Worker values and ways of working. The clash and tension of working as a Peer worker with Peer approaches in a medical model.	Feelings of shame and guilt when working within a system that imposes harm. Out of integrity with self and values. A victim of betrayal feelings of anger and sadness. Feel anxious. Feel bad because I work in a system that treats people so inhumanly in their darkest hours. Feel guilty because I can't speak up. Feel inauthentic. Feeling on guard for negative attitudes from other staff.

Lack of role clarity	Job descriptions not matching what Peer Workers are expected to do. Moving away from personal/professional values for an organisation needs or role demands. No agreed upon skills that are specific to Lived Experience work that sets us apart from other disciplines. Having to re-explain all the time to clinicians what we do and what we don't do. Being put in unsafe situations at work. Peer Worker experienced restricted scopes of practice. A Peer worker is not just a person to answer phones and vacuum carpets because the organisation	Feeling unclear and confused about the point of my work. Feelings of being undermined. Feelings of being underappreciated. Fearing a lack of longevity in the role, and of "bashing my head against a brick wall". Sometimes I feel scared. Feelings like I am less than, dumb, anger, frustration. Unfair Feelings inadequate, and that my role is very misunderstood by senior staff and the organisation.

	doesn't really believe the Peer worker is capable of doing anything else. Lack of an implemented Lived Experience framework. lack of clearly defined safety procedures when working with consumers for the Lived Experience workforce compared to clinical workforce. Unclear organisational protocols.	Hopelessness and frustration Feeling like we don't matter, and no one cares. Feelings of confusion, and that it is not what you know but who you know.
Vicarious trauma	Being witness to restrictive practices is challenging when you have first-hand experience of it. Witnessing and being made a part of restrictive practices which go against Peer Worker values and ways of working. Witnessing unfair treatment; service users not having a voice, being disregarded.	Triggered often. Feeling I am weak. Resistance to go to work. Angry. Frustrated.

	Witnessing human rights violations and discrimination, traumatisation.	Sad about the world. Cynicism or increased pessimism.
Disregard of the Emotional Labour in Lived Experience (Peer) worker.	Emotional labour involved is often silenced, unacknowledged, and invisible. Often triggered by environment, colleagues, and consumer/family stories. No time to stop and process when triggered. Don't want to be seen as unwell. High Peer worker absenteeism. Job Burnout. Burden of Resilience Putting on my happy face for work when my home life is falling apart.	Feeling invisible. Alone. Emotional exhaustion or numbness. Misunderstood. Feeling anxious and like I don't want to go to work. Exhausted. Pressure. Feel inauthentic.

	Having difficulty concentrating at work.	Confusion.
Low reward and recognition	Low wages for the Lived Experience (Peer) Workforce. Not being paid equal to other professionals the wage rate says "less than" or a devalued role. Poor wages often lead to people needing to take on several jobs to make ends meet. Tokenism	Unfair. Injustice. Stressed. Undervalued.
Epistemic Injustice	Assumptions are made about our diagnosis and medication (or even assumptions that we are taking medication). Peer workers need to have a clinician with them when they work. Gaslighting is inherent "vulnerability is ripe for exploitation."	Misunderstood. Angry. Patronised. I feel silenced by clinicians. Unheard.

	Being questioned regularly about our state of wellbeing. Being told you are only a Peer worker, we know best.	Not believed. Hurt.
Poor organisational justice	Workplace cultures are outdated and old fashioned. Toxic workplaces Virtue signalling to make the organisation look good, when really it is not. Mentally unhealthy workplace culture. Stigma Discrimination Workplace inequality	I am under surveillance. Unsafe. They don't really care. They all should know better. Unfair. Hopeless. I feel like I am in survival mode.
High and Low workload	Not being able to work on the ward unless a senior staff member is present.	Useless.

	Pressure to work authentically and meet unrealistic KPI's. Organisational risk adversity towards Peer Workers. Peer workers in clinical setting are not allowed to do overtime because they need to "keep well" whereas nurses and other staff can do overtime. Can't facilitate a group without a clinician present-no clinician- no group- no work.	Stressed. Frustrated. Unfair. Othered. Bored with nothing to do.
Poor support	Lack of support from senior management. Not having workplace needs honoured when expressing vulnerability and honestly. Witnessing challenging professional practice but feeling less able to act due to power dynamics.	Feel like we are just at the bottom of the pecking order. Insignificant. Unsupported. Feel like no one has my back. Voiceless.

Poor workplace relationships including interpersonal conflict	Being on 'show' and questioned regularly about our state of wellbeing. Clinicians speaking disrespectfully about consumers, with and in front of Peer Workers. Power imbalance between Peer workers and non-peer roles. Weaponising of Peer Worker issues When it comes to challenging the status quo and calling out harmful behaviours, blame is often projected onto the individual.	Feeling like clinicians are constantly watching for signs of you "not being well". Not trusted. Disrespected. Undermined. Othered. Hopeless and Helpless. Discriminated against because I have a Lived Experience.

Table 6: Excerpts from focus group summary report on what psychosocial hazards look and feel like in practice.

Discussion

The Code of Practice lists some examples of employees who may be at higher risk of psychosocial hazards including workers with:

- limited work experience (e.g. young workers, apprentices, or trainees).
- barriers to understanding safety information (e.g. literacy or language).
- perceived barriers to raising safety issues (e.g. workers engaged in insecure or precarious work).
- certain attributes, such as sex, race, religious beliefs, pregnancy, gender identity, sexuality, age, or a combination of these attributes, and
- an injury or illness preventing them from performing their full or normal duties.

While the Lived Experience (Peer) workforce have the right to be treated equally like all employees, it is important that employers are aware that some Lived Experience workers may be at higher risk of psychosocial hazards as they identify as having a psychosocial disability. We heard through the consultations that some workplace employers and managers adopt a paternalistic approach to managing their Lived Experience (Peer) workforce. This approach is not recommended and should be avoided.

Participants identified that Peer workers are exposed to many if not all the general psychosocial hazards identified in the Queensland Code of Practice. However, they also identified several hazards more specific to workers using their lived expertise professionally as Peer workers.

Furthermore, focus group participants highlighted how exposure to psychosocial hazards that may be more general in nature often have specific and deeper impact on Peer workers. Hence failure to manage general psychosocial hazards in the workplace may have more specific and serious consequences for Peer workers.

Peer workers identified how exposure to psychosocial hazards led to feelings of further marginalisation, victimisation, disempowerment, othering, and exclusion and that these emotions could and do trigger past trauma.

Workplace culture was referred to as a psychosocial hazard by both survey and focus group participants. Some even referred to their workplace as toxic, stating employees don't feel valued, respected, or supported; there are high levels of stress, poor communication, lack of trust, and little opportunity for growth or development. Toxic work environments make employees feel punished, rejected, guilty, defensive, and humiliated. Employees find it difficult to work in this

environment because of negative behaviours from management and co-workers.

Toxic culture can be the single best predictor of attrition. A recent Australian study "Do I feel safe here?" Organisational climate and mental health Peer support worker experience" [vii] researched organisational culture on integrating and supporting Peer support workers in mental health service delivery. This study provides insights into Peer worker experiences of the workforce, highlighting positive and negative impacts of organisational culture and climate on acceptance and integration of Peer support roles in transdisciplinary settings and echoes responses received in our consultations.

Psychosocial hazards identified by participants in this study, not commonly noted elsewhere, included: moral distress or values clashes, potentially leading to moral injury; disregard of the emotional labour involved in using lived experience professionally; and epistemic injustice.

The unique hazards for Peer workers identified by participants may be associated with marginalisation of Peer workers in the health service not afforded recognition as a unique discipline of practice in the system. Epistemic injustice and devaluing of the emotional labour of Peer workers may lead to moral injury due to workers being put in a position where morals and values are compromised as a cost of being part of the system.

The lack of role clarity experienced by many Peer workers, lack of dedicated Lived Experience supervisory structures, specialised Peer worker practice frameworks and marginalisation in the system leads to Peer workers feeling morally compromised as part of their work. Peer workers experience services exercising power and coercion towards service users, the antithesis of their intention to support their peers to find voice in that system. Instead, they find themselves as part of the administration of that very system.

We asked the Lived Experience (Peer) Workforce about the impacts they experienced because of experiencing Psychosocial hazards in the workplace. The results found that urgent attention by employers is required. Psychosocial hazards can create stress. This can cause psychological or physical harm. Stress itself is not an injury. But if workers are stressed often, over a long time, or the level of stress is high, it can cause harm.

Findings: Peer Workers Recommendations for Change

To establish what the Lived Experience (Peer) Workforce suggest should be done to address the psychosocial hazards in the workplace, we started by asking participants what measures already existed in their workplaces to prevent or manage them. Most cited measures were aimed at supporting the individual to deal with the hazards through options like training, supervision and / or debriefing, and flexible working arrangements.

It was encouraging to see that several measures addressing the source of the hazard present in the Code of Practice[iii] were also mentioned by participants, such as flexible working conditions, culture change campaigns, and Lived Experience frameworks and policies.

Response to managing psychosocial hazard	Percentage (%)
Training	22%
Peer supervision, debriefing, co-reflection	20%
Flexible working conditions	20%
Nothing / did not know	10%
Support and recognition	8%
Culture change campaigns	5%
Organisation-wide wellbeing initiatives	5%
Lived Experience framework and policies	5%
Team meetings	5%

Table 8: Measures in place to manage psychosocial hazards in the workplace.

Both focus group and survey participants commented that Employee Assistance Program (EAP) was often seen as a broad stroke solution, however it was not the solution for unhealthy workplace culture. Organisations need to have plans to address root causes and provide adequate, individualised support to their own employees. When EAP is used as a band aid approach it can cause further harm to employee wellbeing and organisational reputation.

We then asked survey participants "From your perspective, what are three changes that could be made in your workplace to prevent and manage psychosocial hazards for Lived Experience (Peer) Workers to create a workplace that supports mental health and wellbeing?" The top three responses were:

- More Lived Experience supervision
- Consequences for staff who disrespect Lived Experience (Peer) workers.
- Training of other staff about what "Peer" work is /is not.

Thematic analysis of all responses from the survey data and from focus group participants identified seven possible solutions to address the psychosocial hazards experienced by the Lived Experience (Peer) Workforce. Responses included:

1. Increase resourcing.
2. Increase Lived Experience support.
3. Increase knowledge of Peer practice
4. Increase training.
5. Increase Lived Experience leadership.
6. Improve the workplace culture.
7. Increase accountability for poor practice.

1. Increase resourcing.

During consultations we heard that the Lived Experience workforce is poorly resourced regarding budget for training and professional development, including Lived Experienced supervision. One survey participant suggested Peer workers receive a professional development allowance for career progression just like clinicians. We also heard that there is high workload experienced due to understaffing of Peer workers. Another survey participant suggested "Allocating more resources to reduce the burden of our day-to-day work and unreasonable workloads". We also heard from a survey participant that "Government funding is inadequate to allow for the management of hazards robustly".

> *[there is] Insufficient resourcing to enable a Peer worker framework, particularly where there is high 'interpersonal complexity'. In this case, more clinicians are often provided as the answer to workplace issues. For example, rather than resourcing four Peer workers, one overseeing clinician may be employed as the solution to meeting the workplace need.*
>
> ***~Focus Group participant~***

Recommendation

"Organisations engaging Peer workers should conduct a Peer-worker resourcing assessment to ensure Peer workers have adequate career and training opportunities and are adequately resourced for the work assigned to them." (Survey participant).

2. *Increase Lived Experience support.*

Consultations were full of requests for more support, but not from just anyone. Participants were very clear that they needed more support from people with a Lived Experience, people who understood their practice and the limitations and challenges and could help advocate for change and improvements. They felt like they were at the bottom of the pecking order, and no one in the workplace had their back.

Where it is appropriate for external support to be offered to employees, employers should provide the option of paid leave for staff to see their own psychologists or wellbeing support persons, or where external Lived Experience Supervision is already available, and rapport is established, organisations should allow for extra, more frequent sessions, instead of EAP. This is a preferred and more effective option for many people, including members of the Lived Experience (Peer) workforce.

We are not supported, all my requests for support have fallen on deaf ears. We don't even get supervision.

~Survey participant~

Recommendation

Organisations employing Peer workers should ensure appropriate peer-based supervisory structures are in place. This goes beyond professional supervision to including operational supervision so Peer workers can seek managerial advice from a suitably qualified person (a Peer worker).

3. *Increase knowledge of Peer practice*

Both survey and focus group participants shared their frustrations about the lack of knowledge within their workplaces about Peer practice, particularly within clinical disciplines. They reported being asked to do tasks that do not align with Peer practices and are constantly having to explain what it is they do. It is recommended by people of Lived Experience that mandatory training on Peer practice be provided to all non-lived experience staff to increase knowledge and understanding.

Lived Experience (Peer) workers should be line-managed and supported by people from within the peer discipline, who understand.

~Focus Group participant~

Recommendation

Workplaces engaging Peer workers should conduct mandatory training for all staff (including clinical staff) to ensure they are educated and understand the role and practice framework of Peer workers in the workplace.

4. ***Increase training.***

Lived Experience (Peer) Workers would like more understanding of their role through further training and professional development opportunities. Training about Peer Work for clinicians and other staff who don't identify as having a Lived Experience is also vitally important to avoid role confusion, tension and conflict in the workplace and enhance the workplace culture. They also would like more options for Lived Experience training, facilitated especially by Lived Experience Educators as current options are very clinically based, and some are not appropriate for Peer Workers.

Peer work needs to be underpinned by anti-oppressive critical theory, with a strong culture of active engagement with critical self-examination and co-reflection.

~Focus Group participant~

Recommendation

Employers engaging Peer workers should ensure ongoing training and development opportunities are afforded to the Peer workforce relevant to the skills and expertise utilised by the Peer workers.

5. ***Increase Lived Experience Leadership***

Despite the increase in the Lived Experience (Peer) workforce across QLD, there has been little done to increase the Lived Experience Leadership. A lot of responses indicated that by increasing the Lived Experience Leadership in a workplace it would address many of the Psychosocial Hazards. Many senior Peer worker roles are being filled by non-Lived Experience workers. One survey response stated, "Put a lived experience worker in the role as team leader."

Making sure that the Peer Workforce is managed by someone who has an understanding and respect of what Lived Experience is.

~Survey participant~

Another spoke of the need to create more designated Lived Experience roles, making Lived Experience an essential criterion instead of desirable and "the burden of educating the supervisor about the Peer worker perspective, particularly where there is high intersectionality".

Recommendation

Employers engaging a Peer workforce should ensure lived experience is represented at all levels of the organisation. Organisations should audit practices to ensure gender discrimination in recruitment does not exist, so systemic bias does not replicate itself.

6. ***Improve the workplace culture.***

To address and improve the workplace culture Lived Experience (Peer) workers believe employing more Lived Experience workers would help. Changing the culture and philosophy of "professionalism" is required to break down hierarchical barriers.

Employees found it difficult to work in their environments because of negative behaviours from management and co-workers.

Ironically, I work in mental health, and it is the unhealthiest workplace I have worked in.

~Focus Group participant~

Recommendation

Employers should monitor workplace culture closely with particular focus on interdisciplinary engagements and hierarchical barriers to collaboration.

7. ***Accountability for poor practice***

Transparency, accountability, and a fair process for all is required to address this psychosocial hazard. One survey participant suggested to "ensure that workplace rules are applied fairly, consistently and in an unbiased manner. Ensure there is a transparent grievance and appeal process, promote and encourage a positive and fair work environment."

*Name the violence: there must be safety to have courageous conversations and accountability for all who are involved in the conversation ~**Focus Group participant~***

Recommendation

Ensure that workplace rules are applied fairly, consistently and in an unbiased manner. Ensure there is a transparent grievance and appeal process, promote and encourage a positive and fair work environment.

Assumptions/Limitations

This project was a small qualitative study from the perspective of the Consumer Mental Health and Suicidality Lived Experience (Peer) workforce. Other views were excluded from the project including the Family/Carer/Kin, AOD and other Lived Experience (Peer) workforces.

The Project came with an assumption that the Lived Experience (Peer) workforce all had an in depth understanding of what a psychosocial hazard in the workforce was and what was possible to do about them. However, it became evident that many Lived Experience (Peer) workers, and even managers were unsure, or had not ever heard about them, resulting in extra time to define and translate their responses.

A trauma-informed approach was taken to allow participants to tell their story first and in their own language, when trying to identify psychosocial hazards. For example, when asked what a psychosocial hazard was, one participant replied, “Witnessing Homelessness”. The psychosocial hazard underneath this response could be “traumatic events” or” moral distress”, but with only a short amount of time it was difficult to dig deeper, and this was a limitation of the project.

Next steps

This report will inform a position paper that represents the views of both QLEWN and MHLEPQ and will be used by both organisations to inform advocacy activities.

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Appendix A: Survey Participant Work Roles

Survey participants were asked to describe their role, responses are listed:

- Peer support worker
- Lived Experience worker.
- A/Team Leader of Lived Experience workforce.
- Project Manager for lived experience projects.
- Peer Worker
- Lived Experience Peer Supervisor
- Lived Experience Peer Worker in a Community Center
- IPRA (Independent Patient's Rights Advisor)
- Advanced Peer Worker
- Coordinating the Lived Experience Workforce
- Living experience Practice Lead in our Mental Health Team
- Management
- Advanced Peer MH hospital in the home
- Intake and Assessment Worker - Lived Experience
- Peer Practice Leader
- Manager of a team of lived experience workers.
- Lived/living Experience leadership.
- Self-employed Art Therapist
- Lived Experience policy advisor
- Lived experience Peer support assistant.
- Consumer Peer worker
- Peer worker for people with mental health issues

Appendix B: Description of Psychosocial Hazards[1]

Lack of role clarity means workers aren't clear on their job, responsibilities or what is expected. This may happen when they aren't given the right information or things keep changing.

It is more than sometimes being given a complex task. Lack or role clarity becomes a hazard when it is severe (e.g. very little clarity), prolonged (e.g. long term) or frequent (e.g. happens often).

Lack of role clarity may include:

- overlapping responsibilities (e.g. two workers given the same task)
- unclear roles and reporting lines (e.g. unclear who is responsible for what or who is working to which manager)
- conflicting or frequently changing expectations and work standards (e.g. changing deadlines or contradictory instructions)
- not being given information needed to do the job, or
- unclear work priorities (e.g. not knowing which tasks are most important or urgent).

Traumatic events or materials: Witnessing, investigating, or being exposed to traumatic events or materials is a psychosocial hazard.

Something is more likely to be traumatic when it is unexpected, seems uncontrollable or is caused by intentional cruelty. Traumatic events or materials become a hazard when they are severe (e.g. very traumatic), prolonged (e.g. long term) or frequent (e.g. happens often).

Traumatic events or materials may include:

- witnessing or investigating a fatality, serious injury, abuse, neglect, or other serious incident (e.g. working in child protection)
- being afraid or exposed to extreme risks (e.g. being in a car accident)
- exposure to natural disasters (e.g. emergency service workers responding to a bushfire)
- supporting victims of painful and traumatic events (e.g. providing counselling)

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[1] From the State of Queensland, "Managing the Risk of Psychosocial Hazards at Work Code of Practice 2022" [ii]

- listening to or seeing traumatic materials (e.g. reading victim testimonies or an online moderator seeing evidence of a crime), or
- exposure to things that bring up traumatic memories.

Poor organisational justice means a lack of:

- procedural justice (e.g. fair decision-making processes)
- informational fairness (e.g. keeping everyone up to date and in the loop), or
- interpersonal fairness (e.g. treating people with dignity and respect).

It is more than a worker sometimes not getting the shift they asked for. Poor organisational justice becomes a hazard when it is severe (e.g. very poor organisational justice), prolonged (e.g. long term) or frequent (e.g. happens often).

Poor organisational justice may include:

- poor handling of workers information (e.g. not keeping personal information private)
- policies or procedures that are unfair, biased, or applied inconsistently (e.g. favouritism when assigning 'good' shifts)
- blaming workers for things that aren't their fault or they can't control.
- not accommodating workers' reasonable needs (e.g. not making the workplace accessible)
- failing to appropriately address (actual or alleged) issues (e.g. underperformance, misconduct, or inappropriate or harmful behaviour such as bullying), or
- decision-making processes that are poor or which workers aren't told about.

Harmful behaviours can harm the person they are directed at and anyone who witnesses the behaviour. They include:

- violence and aggression
- bullying
- harassment, including sexual and gender-based harassment, racism, ablism, agism, and
- conflict or poor workplace relationships and interactions.

It is more than someone forgetting to say good morning one day. Harmful behaviours become a hazard when it is severe (e.g. very harmful), prolonged (e.g. long term) or frequent (e.g. happens often).