EXPERIENCE IS EXPERTISE:

Improving Peer Employment in BC's Mental Health and Substance Use Sector

Canadian Mental Health Association, BC Division

OCTOBER 2023

Canadian Mental Health Association
British Columbia
Mental health for all

100 years of community

Acknowledgments

This report is dedicated to the peer workers who made invaluable contributions to our research. We are profoundly grateful for your willingness to share your experiences, which have been instrumental in our efforts to instigate positive change.

Furthermore, CMHA BC wishes to express gratitude to those who served on the Peer Advisory Committee and to those who dedicated their time to offer feedback as external reviewers of this report. Your input and commitment are greatly appreciated.

Finally, we also extend our heartfelt appreciation to the myriad peer workers who contribute their expertise to our communities.

Thank you!

We respectfully acknowledge xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish), sə̓lilwətaʔɬ (Tsleil-Waututh), Lkwungen (Songhees) and Wyomilth (Esquimalt) peoples on whose traditional, unceded lands the CMHA BC offices are located.

A note on the text: The definition of words emphasized in purple throughout the report can be found in the glossary on page 67.

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We would like to acknowledge the Vancouver Foundation for funding this project.

vancouver foundation

Project Team

Amelia Moretti is a former Policy Director at Canadian Mental Health Association, BC Division (CMHA BC) with a passion for participatory research, collective advocacy, and social policy reform. Her project leadership included forming the Peer Advisory Committee, hiring the Peer Researchers and Peer Mentor, contributing to the literature review and data analysis, formulating policy recommendations, and being the primary writer of this report. Amelia feels privileged to have been able to create opportunities for people with lived and living experience to see the value of their knowledge, regain agency, and change the systems that have negatively impacted their lives. She hopes this work will continue to create more of these opportunities.

Anita David fills the unique position of Peer Mentor, bringing a wealth of knowledge and lived/living experience as a peer researcher, advisor, co-lead, and mentor on multiple community-based and patient-oriented research projects. She is an advocate for amplifying the voices of lived and living experience and believes in providing a supportive environment where others can discover their strengths and possibilities to use their experience to influence change. Anita's contributions to this project centred around supporting the hiring, training, and advising of the Peer Researchers including providing monthly one-on-one support to each Peer Researcher to work through any barriers personally or professionally. Her favourite part of her work on this project has been connecting during the team meetings and having one-on-one time with the Peer Researchers.

Jessica (Jessy) Knight is a Peer Researcher at CMHA BC with extensive lived and living experience around mental health, substance use, homelessness, poverty, and other social and economic issues. She takes those experiences and uses them to better services, educate the community, and reduce stigma. She is a stark advocate for making things better for those who have had similar experiences to her and compassionately changes all areas she touches. Jessy's contributions to this project include conducting primary research including interviewing, group facilitation, data analysis and interpretation, and providing expertise on the finalization of the report and accompanying resources.

Karolina (Kat) Golik is a Peer Researcher at CMHA BC with over a decade of expertise in peer support work and a lifetime of personal experience navigating the BC mental health system. Kat's considerable contributions to this project include conducting a literature review, conducting primary research including interviewing, group facilitation, data analysis and interpretation, and co-writing the report. Kat is deeply proud of being a part of this team and the work being done to amplify the voices of people with lived and living experience as well as advocate for systemic and structural change to support peer workers and the systems in which they work.

Lenae Silva is a Peer Researcher at CMHA BC with extensive lived experience, including 18 years of opiate use to manage chronic mental health concerns due to barriers within the health care system. She has turned these lived and living experiences into assets as an outreach worker, advisor for harm reduction strategies and education at local and federal levels, and in her work with many organizations to improve their mental health and substance use services. She also co-founded a peer-led organization to pass on these skills to other peers. Lenae feels fortunate to have been brought into this project once it was already in motion and contributed her expertise to reviewing documentation, finalizing project materials, and assisting with knowledge translation. She has found participating in this project to be a great joy and is excited to see the project come together.

Rebekah Erickson is a former Policy Analyst at CMHA BC, driven by her passion for creating a healthier, happier, and more just society through the development of evidence-based policies and programs. With a background in research and policy analysis, Rebekah contributed to the project by conducting a literature review, analyzing and presenting findings, formulating policy recommendations, and co-writing the report. She is grateful to have had the opportunity to collaborate closely with her colleagues throughout the project and learn from one another, as each person brought unique and valuable strengths and experience to the team. Rebekah hopes this research will shed light on the barriers that many peers face in the workplace and lead to more equitable, supportive working conditions for peer workers across BC and beyond.

Additional support provided by **Kendra Milne**, **Kim Mackenzie** and **Alexis Erlichman**.

Members of the Peer Advisory Committee included, but were not limited to **Melisa Edgerly**, **Sarah Irving** and **Debbie Sesula**.

This report was written and edited in an iterative process with contributions from the project team, as well as Kim Mackenzie (Director of Policy, CMHA BC) and Alexis Erlichman (Senior Policy Advisor, CMHA BC) who further refined the report recommendations.

Designed by: **Justyna Krol**

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EXECUTIVE SUMMARY

Peers are persons who apply their lived or living experience of mental illness and/or substance use to the performance of their job duties within the health and social service sectors. Since the release of *A Pathway to Hope*, the Province of BC's mental health and addictions strategy, peer work has been encouraged by government through various initiatives and recognized as a valuable part of BC's mental health and substance use (MHSU) sector. The sector employs peer workers to perform a range of jobs, from support and outreach workers to educators and researchers. The most common position is support worker, where peer roles are restricted to direct service delivery. There are limited peer roles that provide opportunities to contribute to the design, development, delivery, and evaluation of supports, services, and policies in the sector.

The Canadian Mental Health Association, BC Division (CMHA BC) undertook a community-based research project to assess the readiness of BC's MHSU sector for "co-production" or equitable partnerships between peer and non-peer colleagues where they share power and undertake their work together. From April 2020 to fall 2021, the project team sought to learn the current state of peer employment and understand the experiences of peer workers in BC. The mixed methods study combined an environmental scan of peer positions, surveys to peer employers, and interviews with peer workers. This report aims to fill gaps in the literature, which has been largely focused on what can be done at the workplace level, by focusing on systemic challenges and opportunities for co-production.

Despite peer work initiatives stemming from *A Pathway to Hope*, the study found that the BC MHSU sector is far from achieving co-production. Peers are inadequately paid, barred from participation at their work sites, forced to tolerate prejudicial beliefs about their lives and abilities, and stuck within service provision roles that marginalize their voices and viewpoints. Social inequity, exploitation, stigma, and discrimination are significant barriers to the realization of meaningful participation and peer partnership. **This report focuses on three ways to enhance peer work and empower peers in BC: 1) removing barriers to peer employment, 2) creating equitable workplaces, and 3) building towards systems-wide co-production.**

A necessary first step is to remove existing barriers to peer employment. A greater amount and range of peer positions must be made available, and peers must be provided adequate compensation for their work equivalent to their non-peer colleagues. This can be achieved through adequate funding to peer-employing organizations, which will allow them to expand and sustain the peer workforce at liveable wages (with benefits where appropriate), and including peers in provincial strategies to recruit, train, and retain health workers in BC. In addition to liveable wages and to reinforce the value of peer work, peer workers on income or disability assistance should be able to keep their peer employment earnings without experiencing clawbacks.

While important, removing these barriers alone is not sufficient. Workplaces must become more welcoming to peer workers and treat them more equitably. Employers can foster environments that value peer work by dispelling the pervasive discriminatory idea that peer work is an act of charity and by giving the same value to lived and living experience as educational achievement

and work experience. Employers need to clearly define the roles and responsibilities of peer workers and communicate the benefits of the distinct contributions of peer roles to all employees. Employers can offer training to non-peer staff to unpack personal biases and promote greater inclusion. Workplaces can eliminate structural exclusion by providing equitable access to benefits and accommodations. Better yet, workplaces that continue to become more adaptive and flexible can create accessible physical and social environments that eliminate the need for most accommodations. These steps will lead to greater retention, tenure, and respect for peer workers whose numbers must be increased to progress towards equitable partnership for longer-term systemic reform.

Our long-term vision is to build toward system-wide co-production in the MHSU sector, ensuring peers have influence at every level of the system from planning, development, and implementation to evaluation of services, policies, and programs. Professional hierarchies that structure the MHSU sector must be dismantled, and principles of mutual support and experiential knowledge must be held in equal esteem to clinical protocols and professional credentials. While peer workers are well embedded in service provision in BC, they are often still missing from planning and decision-making tables. Until peers are given equal power in these spaces, we cannot achieve co-production in BC.

Based on these findings, this report lays out five systemic recommendations to the Province of BC, across three Ministries and one Independent Office of the Legislature, to remove barriers, create equitable workplaces, and strive towards co-production. We are grateful to the peer workers who shared their experiences with us. We look forward to working with the Province of BC to see these recommendations become a reality so that peers working in the MHSU sector can thrive and the sector itself can benefit from the incredible expertise of peers across BC.

Summary of Recommendations

Removing Barriers to Employment

Enhance access to the peer support work income exemption for all peer workers in BC.

We recommend the **Ministry of Social Development and Poverty Reduction**, in partnership with the **Ministry of Health**, consider enhancing access to the peer support work income exemption for all peer workers in BC by:

a. Expanding eligibility for the income exemption from only peer support work to include all types of MHSU peer work where lived and living experience is a qualification for the position and necessary for the performance of job duties;

b. Developing a clear way of accessing and systemic way of processing the peer work income exemption, including eliminating the need for peer-employing organizations in the MHSU sector to be “designated agencies” through a health authority;

c. Developing educational resources for employers on how to facilitate the exemption for peer workers who are on income or disability assistance; and

d. Working with community partners to co-develop and distribute resource materials to peer workers to understand their eligibility and process for applying for the exemption.

Increase opportunities for peers and improve peer work conditions within the MHSU sector.

We recommend the **Ministry of Health**, in partnership with the **Ministry of Mental Health and Addictions**, consider continuing the work that began in *A Pathway to Hope* to increase opportunities for peers and improve peer work conditions within the MHSU sector by:

a. Recognizing peer support workers in the Health Human Resources (HHR) Strategy, which includes MHSU services as a priority area;

  i. For example, the Ministry of Health could include peer workers in the new employer-sponsored 'Earn and Learn' programs (Action #53 of the HHR Strategy), to reduce financial and other barriers to training and offer viable career growth opportunities for peers who want and are in a place to grow their careers;

b. Mandating that any paid peer positions in the MHSU sector funded by the Ministry of Health or the Ministry of Mental Health and Addictions, either directly or contracted through partners (e.g., health authority, community-based organization), are provided a livable wage and benefits on par with similar non-peer positions, and;

c. Creating a funding stream exclusively for peer employment that is accessible to health authorities, non-profits, and peer-run organizations that are part of the MHSU sector. Employment conditions such as a livable wage, benefits, and providing the income exemption should be mandatory eligibility criteria to apply for and receive the funding, which should be reviewed annually and be provided on a recurring, annual basis to organizations that continue to meet the conditions.

Creating Equitable Workplaces

Fund a peer-employing organization to develop and deliver training for MHSU organizations on the role and value of peers in the workplace.

We recommend the **Ministry of Mental Health and Addictions** consider dedicating funds for a peer-based or peer-employing organization to develop and deliver training to MHSU organizations on the role and value of peers in the workplace, the risks associated with re-traumatization in the workplace, and strategies to foster a trauma-informed and stigma-free workplace.

The training could include components by and for Indigenous organizations that address the ongoing harms of colonialism, culturally safe practices, Indigenous concepts of holistic wellness, and principles of self-determination.

Expand current guidelines on employment equity to increase inclusion of persons who have mental health and/or substance use-related disabilities.

We recommend the **BC Office of the Human Rights Commissioner** consider expanding their current guidelines on employment equity to include examples of accessible workplace practices and intersectional accommodations that employers can enact and offer employees to increase inclusion of diverse persons who have mental health and/or substance use-related disabilities.

The guidelines should specifically address peer workers, where the nature of their role may require them to disclose at least the existence of a health issue or disability or an aspect of their identity that is often subject to discrimination, and provide guidance to employers on the fulfillment of human rights obligations.

Establish a new Independent Office of the Legislature called the BC Office of the Mental Health Advocate.

We recommend the **Government of British Columbia** consider establishing a new Independent Office of the Legislature called the BC Office of the Mental Health Advocate. The Office should be composed of a committee of members who possess lived and living experience of mental illness, substance use, and public service access.

The Office's role will be to receive and resolve complaints from service users, conduct systemic investigations, produce public reports, and provide recommendations for reform directly to the Legislative Assembly of BC to support all Members of the Legislative Assembly to monitor and assess government programs, procedures, and performance.

INTRODUCTION

Peer can mean many different things depending on the context. The term refers to two or more people who share an experience or an identity. The most common usage is **peer support** whereby two people who are similar to one another provide each other mutual assistance. In the context of the mental health and substance use (**MHSU**) sector, and for the purposes of this report, a "peer" refers to a person who possesses lived or living experience of a mental illness and/or using substances.

Peer employment is almost a contradiction. Peer suggests a social relationship between equals, while employment entails a transactional and hierarchal relationship between an employer and an employee. While peer support is the most common form of peer employment, many other positions exist wherein a person applies their knowledge and personal experience of mental illness or substance use to a range of jobs across the health and social sectors. The title of "peer" indicates their knowledge is intimately tied to their life experience and identity, which differs and separates them from non-peer colleagues whose credentials come from formal education and prior employment.

Research on peer employment largely centers on the benefits of and best practices for peer support to treat MHSU conditions. Studies that include other forms of peer employment tend to focus on fair wages and material conditions, rather than job duties. Topics such as the application of experiential knowledge and the dissonance that results from the structure of work environments that reinforce separation of employees' personal and professional selves are rarely addressed.

[C]o-production is an equitable relationship where peer and non-peer colleagues share power and partner on the design, development, delivery, and evaluation of MHSU supports, services, and systems.

The Canadian Mental Health Association BC Division (**CMHA BC**) undertook a mixed methods community-based research project on peer employment and empowerment within the BC MHSU sector. The research aimed to understand this latter structural dimension for the purposes of assessing system readiness for **co-production**. **Our project made a distinction between peer employment and low-barrier employment.** Both often employ persons with lived and living experience of mental illness, substance use and/or other conditions of marginalization, but peer employment necessitates the worker apply their experiential knowledge to their job. Some peer employment may be low-barrier employment, but not all low-barrier employment is peer employment.

In this context, co-production is an equitable relationship where peer and non-peer colleagues share power and partner on the design, development, delivery, and evaluation of MHSU supports, services, and systems. The fundamental difference between co-production and standard employment relationships is the distribution and exercise of power. Workplaces are commonly predicated on hierarchies. Peers are often at the bottom with very little power over the terms of their employment, their job duties, and their working conditions.

The primary question at the root of our research was how to shift that power imbalance and redistribute power to position peers as equal to their non-peer colleagues. Our findings indicate that livable wages and pay equity are necessary but not sufficient. The achievement of co-production requires a transformation of the employment relationship and the surrounding system that not only equalizes power between colleagues and their employer, but also strives to create universally inclusive and accessible workplaces and services.

Peers first need to receive compensation equal to their non-peer colleagues to provide a stable financial foundation for them to participate at work and slowly undo the prevalent belief that experiential knowledge is less valuable than education or employment credentials. Workplaces then need to adapt to be more inclusive of persons who have diverse identities and abilities and strive to eliminate the prevalence of stigma and discrimination. The Province of BC can then look to these workplaces as examples to begin to reform the **MHSU system** and employ peers themselves to monitor, oversee, and contribute to that transformative work.

The sections that follow document not only what we learned and where to go next for systemic reform, but also our process for practicing and researching co-production. We tell our story to document the centrality of relationship, trust, and shared accountability to the project. The voices and reflections of the project team—Policy Director, Policy Analyst, Peer Mentor, and Peer Researchers—are woven together to illustrate the challenges, tensions, and ultimately rewards of this work. While first-person narration is unorthodox for a report of this nature, our story offers a form of written peer support to others who are undertaking similar systems change work, and demonstrates the necessity of moving away from professionalism and towards a more personal approach to enact meaningful partnership.

It is important to note that the project was initiated April 2020 shortly after the COVID-19 pandemic was declared a global health emergency. The public health interventions intended to curb the spread of the virus unintentionally amplified the continued harms and deaths caused by the drug poisoning epidemic. In some areas, organizations had to close their doors and **peer workers** stepped forward to provide outreach and help to those who had no place to shelter and self-isolate. Our research was consequently put on hold. Interviews with peer workers did not take place until Spring-Summer 2021, with the analysis and composition of this report taking place over 2022 and 2023.

This report is the culmination of a three-year endeavour and a collection of diverse knowledge from lived and living expertise, to academic research, to policy analysis. Our aim is not only for our recommendations to be considered by entities within the Province of BC, but also for our experience to offer instruction and hope to other peer-employing organizations that aspire to co-production. Every peer worker employed, and every workplace committed to co-production, is a call for change that the Province of BC cannot ignore. BC is far from co-production, but with enough momentum, we can build towards its realization.

METHODOLOGY

Research for the project consisted of four components: literature review, peer positions map, peer employer survey, and peer worker interviews. The literature review collected recent research (2010–2021) on peer employment to understand the existing knowledge on the topic and further refine our area of study. While peer support is a widely researched topic, peer employment and co-production were less well-researched. Minimal research existed on the current state of peer employment and the application of co-production principles and practices across the BC MHSU sector. This knowledge gap informed our mixed methods approach that combined an environmental scan, surveys, questionnaires, and interviews.

The project was guided by a Peer Advisory Committee composed of peer workers from across the province who have lived and living experience of mental illness and/or substance use and apply that experience to their healthcare and community sector jobs.

Mapping Peer Employment in BC

In May 2020, the peer research team conducted an environmental scan to identify where peers were employed across the province and the types of positions they held. The scan focused on six areas of BC where peer programming and services are offered: Lower Mainland, Fraser Valley, Vancouver Island, the Interior, Northern BC, and province-wide programs.

We first consulted with our Peer Advisory Committee to develop a preliminary list of organizations that employ peers, then generated key search terms (e.g., “peer,” “experiential,” “support worker,” “lived experience”). The peer research team input these terms in Google and scanned through organization websites to gather information on the peer programming they offered. We then contacted program staff over the phone, social media, or via email to ask a series of questions about the number and types of peer positions, the programming offered, and the populations served.

Employers Survey

To find out more detailed information about the employment conditions of peer workers in BC, our peer research team developed an online survey to send to employers identified in the mapping exercise. The survey included 46 questions on topics such as recruitment and training, compensation and benefits, unionization, peer roles and responsibilities, workplace policies,

integration within multi-disciplinary teams, management and supervision, and the impacts of the COVID-19 pandemic on peer programming. In March 2021, we sent the anonymous survey to 151 employers, out of which a total of 59 completed it. We performed a descriptive analysis of the data using Qualtrics, examining the differences in employment conditions between the types of organizations (peer-run groups, health authorities, and not-for-profit organizations) and across the different regions of BC.

Peer Worker Interviews

Participant recruitment involved both nominations from our Peer Advisory Committee and invitations sent by the Peer Researchers to peer-employing organizations identified during the mapping exercise. Eligibility was limited to adult peer workers (19 years of age or older) who were employed in the mental health or **substance use sector** in BC. Although it was not possible to ensure a fully representative sample, the project team selected peers who represented a wide variety of job positions, levels of seniority, demographic backgrounds, and geographic locations. We also selected an equal number of peers working in mental health, substance use, and combined MHSU-related jobs.

From April to July 2021, our peer researchers conducted 26 one-on-one interviews and one four-person focus group, interviewing a total of 30 peer workers from across the province. The interviews consisted of six questions that focused on the participants' employment history, relationships with peer and non-peer colleagues, experiences of empowerment and disempowerment at work, career or personal goals, and changes they would like to see for peer workers across BC. We also collected demographic information through a short pre-interview questionnaire. Each participant provided their informed consent to participate in the 1-hour interview and received a $25 **honorarium** as compensation.

Our peer researchers conducted the interviews over the phone and recorded them using a hand-held recording device to later transcribe. The project team then undertook an inductive thematic analysis[1] where we familiarized ourselves with the data by transcribing and re-reading transcripts, created an initial set of codes, conducted a second review of the dataset based on the codes, created a data extraction sheet to assign transcript excerpts or quotes to codes, and reviewed and refined the dataset. To account for bias, we had two members of the project team review each transcript, a peer researcher and another policy team member. In instances where there was a different interpretation of an excerpt from a transcript, the two members would discuss and deliberate to decide on which code best applied. The findings are summarised and presented in the sections that follow.

Limitations

Research presented throughout this report should be considered a snapshot of peer employment, rather than a full representation of the BC peer workforce. The scope was limited to peer workers who apply their experiential knowledge of mental illness and/or substance use to the performance of their job duties and does not include peer workers with other types of lived and living expertise (e.g., sex work peers, HIV positive peers, etc.). The environmental scan depended on up-to-date

1 Inductive thematic analysis is the process of coding data without trying to fit it into pre-existing codes based on analytic preconceptions.

online information, the response rate for our employer survey was less than 40%, and the modest sample size for our peer worker interviews is not representative of the workforce.

Additionally, given the methodology of our environmental scan, we acknowledge that we were likely to only reach the more established peer positions, and therefore most of the report focuses on public and non-profit health and social sector employment. Further research is needed to understand the experiences of peers who work in more grassroots, less institutional settings who may experience peer work differently.

These limitations reflect the realities of a time-limited community-based research project and should be considered when reading this report.

Finally, the scope intentionally does not include forms of low-barrier employment wherein someone who possesses similar lived experience performs a job to support their community, such as street clean-up. While these important employment opportunities are sometimes referred to as peer work, they do not meet the definition of peer work established in this report.

CO-PRODUCTION

This section documents our story of both practicing and researching co-production to illustrate the practical considerations and personal contributions necessary to establish and sustain meaningful partnerships between peer and non-peer colleagues.

Our Story of Co-Production

Integral to co-production is sharing power. We attempt to dismantle hierarchies as much as we can in a naturally hierarchical world. We never make decisions in isolation. All staff are called upon to provide their input and we use our shared knowledge to reach a consensus.

The UK New Economics Foundation (NEF) defines co-production as "a relationship where professionals and citizens share power to plan and deliver support together, recognizing that both partners have vital contributions to make in order to improve quality of life for people and communities." (1) The definition focuses on service provision as well as the relationship between service providers and the recipients of those services. The central question for our research was two-fold: 1) how to apply the concept of co-production to an employment, rather than service provider relationship and 2) how to assess the readiness of BC's MHSU sector for co-production. The uniqueness of our project was that we were practicing and researching co-production simultaneously.

The following section is a first-person narration of our experience. While unorthodox for a report of this nature, the narration documents the centrality of relationship, trust, and shared accountability to co-production. We learned early on that partnership necessitated that we dismantle the strict boundaries of professionalism and relate to one another with honesty and humility. Our story illustrates this and intends to share not only how to do this, but also what the impacts of doing this were.

The narration includes my reflections, Amelia Moretti, former Policy Director, and those of the Peer Researchers Karolina (Kat) Golik, Jessica (Jessy) Knight and Lenae Silva. One voice is notably absent: Rebekah Erickson, a Policy Analyst, who contributed to the research and composition of this report and was a valuable member of the team for a significant portion of the project. Her contributions are woven into the narration, but are retold from the perspective of myself and the Peer Researchers.

The Early Days

I had no idea what to expect before undertaking the peer employment project. I had read the literature on co-production and understood the ethics underpinning the work, but the reality of implementing co-production amidst the confines of traditional employment structures was much different.

The first step of the project was forming a Peer Advisory Committee ("the Committee") of peer workers from across the province who had lived and living experience of mental illness and/or substance use and applied that experience to their healthcare and community sector jobs. Tensions occurred almost immediately when early discussions turned to the scope of the research. The Committee was split between encompassing both the MHSU sectors and focusing only on the **mental health sector**. The arguments centred on inclusivity versus feasibility. The budget and timeline of the project placed limits on the possible breadth of the research activities. After multiple discussions at committee meetings and between myself and members, a decision was made to include both sectors.[2]

2 Despite the differences between the MHSU sectors, there is significant overlap. Given that the scope of this report includes both, the report will refer to the MHSU sector as a singular sector unless otherwise indicated.

The next step was to create the research team. The Committee was clear that the Peer Researchers had to have experience of mental illness and/or substance use and an understanding of BC's system of care, but not necessarily peer work. The intention was to create a low-barrier opportunity for anyone who had lived and living experience. A job description was drafted based on this direction but left unposted for months. The Committee placed importance on fair wages, union membership and access to benefits, and emphasized that these conditions were necessary for the Peer Researchers to enter the organization on equal footing. The challenge was that no job like theirs existed under the CMHA BC collective agreements.[3] Since the wage grids were determined by educational attainment, work experience, and seniority, the only job that had a low enough barrier to entry was a Support Worker. Similar research positions necessitated graduate degrees. I had to advocate for the creation of a new position[4] and wait for the classification process to unfold.

Skills were taught and shared between all members of the team to prepare us for each phase of the research. Jessy noted the importance of "stepping away from the idea of capacity building that has the underlying intention of coercing people to fit within tidy professional boundaries that are fueled by ideas of individual success and productivity. Instead, our focus was on capacity bridging where we share and match our skills to raise our community value. Skills building was used to add to communal power."

Jessy acknowledged that "the project took the time to set up a strong foundation for us to enter the organization. A Peer Advisory Committee was involved in every step of the set-up and ensured best practice wages, benefits, and inclusion within the CMHA BC organization (e.g., email and office space), and flexibility from the funder on timelines. There was time and care put into making sure there were strong bones that would be able to support successful co-production."

The job posting went up and was widely shared by the Committee. We received 150 applications. We had originally intended to create a subcommittee to review the applications and discuss them over the course of an afternoon, but had to pivot to a more standardized process. After considerable deliberation on the skills, knowledge, and experience most relevant to the position, we created a scoring rubric that assessed for a deep understanding of the MHSU system and a willingness to learn the skills needed to do their work.

At this time, we brought on Anita David, who was on the Committee, as a contracted Peer Mentor to support the hiring process. We then had two reviewers from a panel of three (Policy Analyst, Policy Director, and Peer Mentor) read and score each application. The process was painfully imperfect. Every application was vastly different since the job posting had few discrete qualifications and applicants were given the choice to either fill out an online questionnaire or submit a cover letter and resume. Some applicants disclosed details of their lived experience, while others focused on education and work experience. Each reviewer read the applications differently and prioritized

3 A collective agreement is a contract between unions and health and community sector employers.

4 Please refer to Appendix A for the job description.

different aspects of them. The scores ranged and many impassioned conversations took place until we decided on a cohort of 16 applicants for phone interviews, and following the phone interviews, another six applicants for Zoom interviews.

The recruitment process was the first instance where power imbalances created a sense of unease. Until then, the Committee acted on consensus and no one member had the power to direct the outcome of any decision. Only three of us acted as reviewers, two non-peer staff and one Committee member. We held decision making power over who was hired and who was not. Every time I sent an email to notify someone that their application was unsuccessful, I felt the discomfort of disappointing them and doubted that the right decision was made or the process we created was truly fair. In future competitions, we agreed to more clearly define job qualifications, create a scoring rubric based on those qualifications before posting, and provide clearer instructions to applicants on how their applications would be assessed. Despite the success of the recruitment, I could not help but reflect on all the tiny decisions that closed the door to 148 applicants and opened it to two.[5]

The Project Team Assembled

The selected Peer Researchers, Jessy and Kat, joined the project. Their employment started with an orientation to CMHA BC and an introduction to their Peer Mentor, Anita David, who led a series of workshops on community-based research. Kat noticed early on that "there was the utmost attention paid to training and guidance. We were given the tools to participate and provide equitable contributions throughout the process and were never diminished to our mental health or personal issues." Knowledge and skills were positioned as a means of empowerment. Kat continued, "I was learning new skills all the time — some practical like spreadsheets and literature reviews, and some more personally empowering like public speaking and interviewing people. We could share our strengths with each other and apply the skills in a real setting. I was not limited by my title of peer."

The idea was **capacity bridging** rather than **capacity building**. Skills were taught and shared between all members of the team to prepare us for each phase of the research. Jessy noted the importance of "stepping away from the idea of capacity building that has the underlying intention of coercing people to fit within tidy professional boundaries that are fueled by ideas of individual success and productivity. Instead, our focus was on capacity bridging where we share and match our skills to raise our community value. Skills building was used to add to communal power."

The Realities of Power

The foundation we laid through capacity bridging supported the development of our Power Assessment Framework ("the Framework"). To effectively share power and assess distributions of power across the MHSU system, we needed to be able to pinpoint what power was and how it was used and experienced. The Framework consists of five indicators of power—financial security, self-determination, values alignment, opportunity, and influence—as well as scales to differentiate experiences of no power, some power and full power. Many iterations were developed

5 A third Peer Researcher, Lenae Silva, who is mentioned later on during this narration, was hired through this process to work on another community-based research project—OD Prep, which highlighted essential practices for overdose and drug poisoning prevention and response from across BC. When her role on that project wrapped up, she was transitioned to this project.

and workshopped with the Committee and the team began to see the Framework as more than a research tool. We saw potential for it to provide practical support to workplaces to assess and redistribute power between peer and non-peer staff. We decided to pilot this idea and hosted workshops with peer workers and their non-peer colleagues at six different work sites.

Kat and Jessy explained to me the precarity and the constant fear of losing employment and income when the experience you bring to the role can easily become the reason for your dismissal.

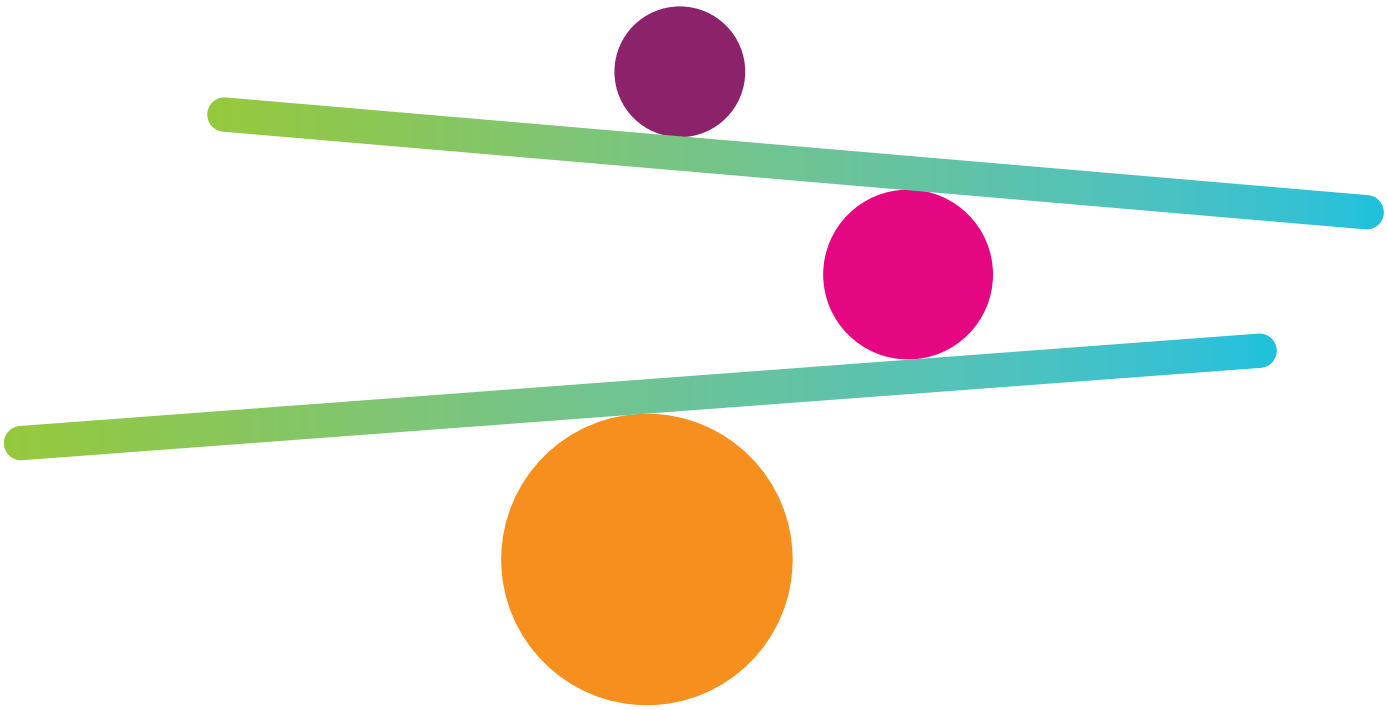
The first workshop was fastidiously prepared for. Both Kat and Jessy expressed nervousness about stepping forward to co-facilitate. The topic of power is difficult to discuss, and the dynamics of a workplace are hard to predict. In some ways the workshop proceeded as planned. We shared the Framework and facilitated discussion to support their development of an empowerment plan, but conversations took place between the Peer Researchers and peer workers behind the scenes that indicated an absence of safety. Many peer workers felt uncomfortable that their manager was present; others were triggered and disclosed mental health challenges to Kat and Jessy. I learned about this afterwards. I felt my responsibility was to maintain a safe space for participants and professional boundaries for my team and panicked when I learned about one participant who was struggling. I immediately felt obligated to act and notified their manager of their need for support. While the action momentarily eased my panic, I would soon realize that my intervention may have made matters worse.

I received an email the next day co-written by Kat and Jessy that respectfully explained that my actions could have worsened the power imbalance between the peer worker and their manager and risked the peer worker's health and employment. They asked for a meeting to share their perspective and better understand my reasoning. My heart sank. I alternated between anxious anticipation of the conversation and indignation that what I did was justified. I soon realized that despite my research on peer employment and my role co-developing this project, I still did not understand what it was like to be a peer worker. Kat and Jessy explained to me the precarity and the constant fear of losing employment and income when the experience you bring to the role can easily become the reason for your dismissal. Peer work is unlike any other healthcare or social service position. Peer workers need flexible boundaries between their personal and professional selves to relate and support clients, but are still required to neatly separate these selves when engaging with their employer and sometimes colleagues. The tension is ever present.

Our conversation led to a new level of trust between us and a renewed commitment to shared decision-making. Jessy reflected that "we are all unpacking our cultural backpacks, whether that is peers adapting to being within a safe space where they feel heard and respected or professionals learning to interact in ways outside of how they have been conditioned by years of working within professional spaces. You can announce that a space is safe and have all the best practice checkmarks, but that does not undo years of internalized stigma and systemic violence. Part of the healing is participating in the change, having a voice and impact on your surroundings, and understanding that this is an ongoing process with limitless potential for growth. The project was being built upon new foundations of safety."

Kat shared her desire to create the safety for other peer workers that she herself felt: “my role felt safe for me. I felt safe sharing my perspectives and insights without **tokenization** or judgement. I knew my job was secure and representative of the value I brought to the project and organization.” Jessy observed that our divergent perspectives were at the heart of the issue: “we are creating spaces where people can feel supported and be honest about their needs and boundaries—where we can unpack harmful and dangerous power dynamics and replace them with inclusion and new definitions of value and appreciation for what people have to offer that may not fit within traditional professional lines.”

The remainder of the workshops preceded on this new foundation. Participants provided valuable feedback for our research and our Framework supported workplaces to move towards co-production. Lenae, a participant in one of the workshops (who later joined this project as a Peer Researcher) reflected that the workshop “was really well received. I found that the project documentation and ideals shone a light onto the gaps in employee care that even the best-run organizations had. The assessment documents and the breakdown of the common complaints from peers opened the eyes of team members and leaders. It led to co-production. The bosses took feedback better, engaged in how employees were feeling at their positions, how fulfilled they felt, etc.”



The Continual Balancing Act

The Power Assessment Framework and workshops made us question the applicability of the NEF definition of co-production and the importance of iterative reflections on our process. We taught others to assess and redistribute power and committed to doing the same. We adapted the six principles laid out by NEF and created a reflective worksheet to document our observations and interpretations.

SIX PRINCIPLES OF CO-PRODUCTION

There are six principles of co-production (adapted from NEF) that we applied to the design and implementation of this project to strive for equitable power sharing:

 **1. Strengths-based**	Project team members receive recognition for their abilities and are equal partners in the design, development, execution, and evaluation of the research.
 **2. Capacity bridging**	Project team members learn from one another and build their skills and knowledge. There is intention and action to build capacity at the individual and organizational level.
 **3. Reciprocity and mutuality**	Project team members have reciprocal relationships, where there are shared responsibilities and expectations.
 **4. Peer networks**	Project team members are allotted paid time and regular opportunities to engage with their peers and support one another.
 **5. Power sharing**	Project team members contribute to consensus-based decision-making that moves away from top-down hierarchies and prioritise open dialogue.
 **6. Empowerment**	Project team members are empowered to pursue their goals and ambitions within and beyond the project.

Our commitment to authenticity meant that we turned our critical lens toward ourselves. I realized that power imbalances are common among organizations and equitable power distribution requires constant attention to changing dynamics. At times, me simply being present shifted the balance. The only remedy was creating spaces I was not a part of. Regular meetings between the Peer Researchers and their Peer Mentor who was not part of the organization was one way of doing this, another was setting aside time for the Peer Researchers to work together independent of me.

Kat acknowledged that “having multiple peers with different backgrounds and skills on the team made it easier to speak up and share our perspectives. Our Peer Mentor provided training to strengthen our skills, helped us navigate a changing workplace, and was available to answer our questions.” Lenae similarly felt that “meeting with a non-biased Peer Mentor who supported me

on both a personal and work level allowed me to continue with work when I was overwhelmed with anything—life, work, etc. I don't think I could have continued with all aspects of work without that one-on-one support." The presence and constant support of a Peer Mentor and fellow Peer Researchers was critical.

Jessy reflected that "Kat really challenged me to think differently about aspects of peer work. She gave me a deeper understanding of what different generations of peer workers have gone through at the hands of systemic violence. It has really shown me that despite the massive variety in peer work there is so much commonality in our experiences. The nature of this work gives us a built-in ability to help support each other through it."

The Heady Days of Achievement

The foundation for the project had been built. Relationships, trust, and a shared accountability to maintain co-production meant that we were ready to begin the research. Kat and Jessy began by mapping all the peer positions across the province. Our understanding of the geographic distribution and vocational variety of peer work then informed an employer survey to assess current employment conditions (e.g., wages and benefit entitlements) and peer worker interviews to understand their experience of their employment. We then analysed and themed the findings as a team.

We had another team member join around this time, a Policy Analyst, Rebekah. Her recruitment was co-led by the full team. Kat, Jessy, and Lenae joined interviews and deliberated on candidates. The decision on who to hire was made by consensus. The result was a new team member who not only understood the values and practice of co-production, but also meaningfully contributed to the capacity and emotional resilience of the team.

We all felt incredibly proud of what we had achieved. Our project truly was practicing and researching co-production. Jessy agreed that "the most rewarding part was the process around the interviews. There was a perfect balance of self-sufficiency, structure, and teamwork at different points. This component of the project needed a certain amount of trust in us to be successful. We had good communication that included input from outside our bubble and collaboration within the team."

A combination of emotional intelligence, experience, and willingness to work with an open mind had given us the space to unpack internalized stigma, feel safe and supported while we learn together." Jessy continued that "the openness and trust we had between our different roles helped us have a 360-degree understanding of the stresses going on with everyone's role. It helped build empathy and a deeper understanding of where each member is coming from."

The Emotional Toll

The truth was I was exhausted. We may have achieved co-production for our research project, but the remainder of the organization

still operated on principles of hierarchy and scarcity that are all too common for non-profits. My working hours steadily increased, my responsibilities grew and aspects of the project that were integral to equitable power sharing started to fall away. We no longer met regularly with the Committee, membership started to drop off and my contributions slowly diminished. The foundation we had built had to be maintained, but I could not do my part and felt guilt every time I joined a Zoom meeting late and unprepared or left an email unanswered. I knew on a certain level I could not do both. I could not occupy a typical leadership role where top-down decisions led to a frenetic pace of reactive work and co-produce a research project that prioritized relationships, trust, and transparent communication above all else. The two ways of working were antithetical to one another.

In my hectic mindset, I believed my stress was imperceptible to the team, but they knew me and could see the change taking place. Their response was nothing other than compassion. Jessy acknowledged that "building teams with the desire and capacity for co-production is difficult emotional labor. The act of tearing down harmful power dynamics to allow for genuine team building, skills sharing, knowledge sharing and safety where everyone on the team has the support and personal security to contribute in an honest way that reflects their experiences and values can take a toll."

The team assured me that "having a strong project lead with a deep understanding of peer work was essential to our project's recent success. A combination of emotional intelligence, experience, and willingness to work with an open mind had given us the space to unpack internalized stigma, feel safe and supported while we learn together." Jessy continued that "the openness and trust we had between our different roles helped us have a 360-degree understanding of the stresses going on with everyone's role. It helped build empathy and a deeper understanding of where each member is coming from."

The peer project meetings became a haven for me. The feeling of being part of a team so committed to supporting one another is indescribable, but eventually I made the difficult decision to leave the organization. My exhaustion was not a small part of my rationale. I knew I needed to prioritize my own well-being but leaving was harder than I anticipated. I was devastated because I cared about them, valued our relationships, and believed wholeheartedly in our work. I knew the project would be completed without me, but my leaving felt like failure and marked a certain end.

In the aftermath, the team observed that "the responsibility falls on the employers to create a space where co-production can flourish" and posed the questions "how can we collectively identify these barriers and name the harm they have caused good work and workers? How do we support our allies instead of setting them up for burnout and disengagement?"

The Fallout and Frustrations

My role on the project was left unfilled for a considerable stretch of time. The team observed that "co-production started to deteriorate once leadership was pulled in many different directions. Without the proper built-in support, we were unable to maintain continuity on the project and practice intentional team building. Some of the issues that arose were limited participation of some Peer Researchers who were working casual hours (rather than regular hours), schedule conflicts and workload pressures from the many other jobs the Peer Researchers had outside

the organization. “While we tried to match the spirit of the project and maintain integrity, we lost momentum at different points.” Jessy pointed to “the knowledge translation pieces, specifically. It was difficult to maintain that momentum, knowing the burnout felt by everyone, the lack of leadership, and that our allotted hours meant that not many of the things we put into the work would be used. It was frustrating trying to put energy into something that did not contribute to the growth of the project. It just left me feeling like there was a lot of unfinished business that we would never be able to get to.”

Lenae, who joined the project after my departure, observed that her experience of onboarding onto the team “was initially where I saw co-production start to fail. I came onto a project that was created by a small group of people with an intense passion for the work. Very intelligent and strong people who put all of themselves into the project. It made me feel as if I was an outsider looking in for a period of time. Both the current team and myself were unclear of what exactly my role would be when I joined, which led to my feeling that the existing staff wanted to protect the project that they had worked so hard on. Onboarding an outside person was difficult.” The situation was exacerbated by minimal accountability structures and other challenges associated with the extended changeover of project leadership. In the absence of a Director, Rebekah stepped up and attempted to empower other members of the team but experienced barriers related to the staff structure and the limitations of collective agreements. Despite her intentions, work ethic, and commitment that were greatly valued by the peer research team, she did not receive an adequate amount of organizational support to effectively fill the leadership void.

The team eventually rebalanced the internal dynamics. Lenae went on to say that her experience was “beautifully salvaged by our CMHA BC team and strong leadership that took feedback and concerns well. The new Director actively encouraged feedback and created structures to hear our concerns loud and clear. I believe my concerns were heard and so were the concerns of the others. That feedback was taken, and management of the project was adjusted to find common ground amongst all staff on the team.”

The Final Chapter

Similar to the Policy Analyst recruitment, the team co-led the recruitment for my replacement and helped to onboard a new Director who could provide the leadership and support necessary to finish the project and rebuild the foundation for co-production. Despite the challenges, occasional disheartenment, and uncertainties, no one on the team would say co-production was not worth it or impossible.

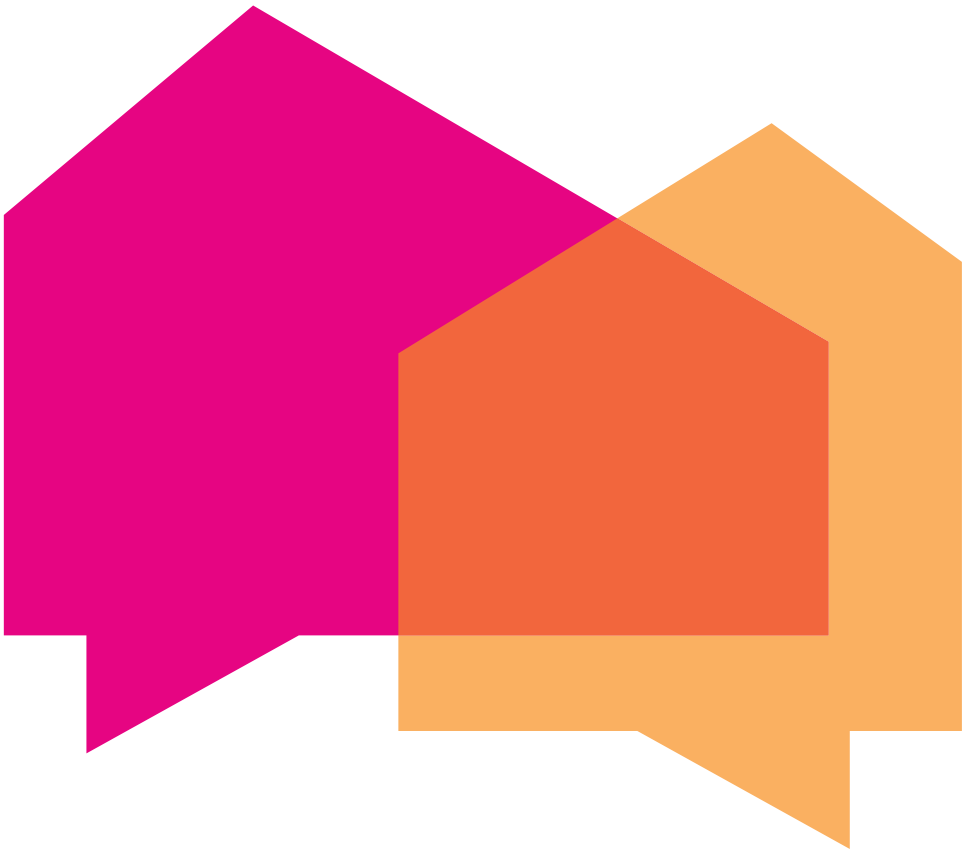
Lenae observed that “true co-production can take a team to the next level. We are all strong, passionate, powerful people, which can often create a clash, but these character traits become the positives they always were when we commit to sharing power and recognizing each other’s contributions.” Kat added that, “in a naturally hierarchical world, it can be difficult to implement power-sharing between peers and non-peers, but it is necessary to avoid the ongoing tokenization experienced by peers. There have been many challenges and growing pains doing this work; however, the sense of fulfillment has been extraordinary. One of the most meaningful outcomes of this work for me personally, beyond the relationships I have built, has been the sense of empowerment I receive from having stable employment as well as receiving ongoing

support to pursue formal education and skills development that previously had been inaccessible to me. Most of all, however, we are a community of people, non-peers, and peers who share the same values of working together for the betterment of people working in and accessing services in the MHSU system."

Jessy connected our struggle and achievement to the broader systemic changes that are needed: "There is a massive shift that needs to happen within our MHSU systems. At the root, I believe is the learning and action we are undertaking to make these spaces accessible and support the participation of peers in a meaningful way. Genuine co-production between peers and professionals will benefit everyone and create the shift we need."

WHAT WE LEARNED

This section provides a snapshot of peer employment in BC, from 2020–2021, based on our primary research that included mapping peer positions, administering a survey to peer employers, and conducting interviews and focus groups with peer workers.



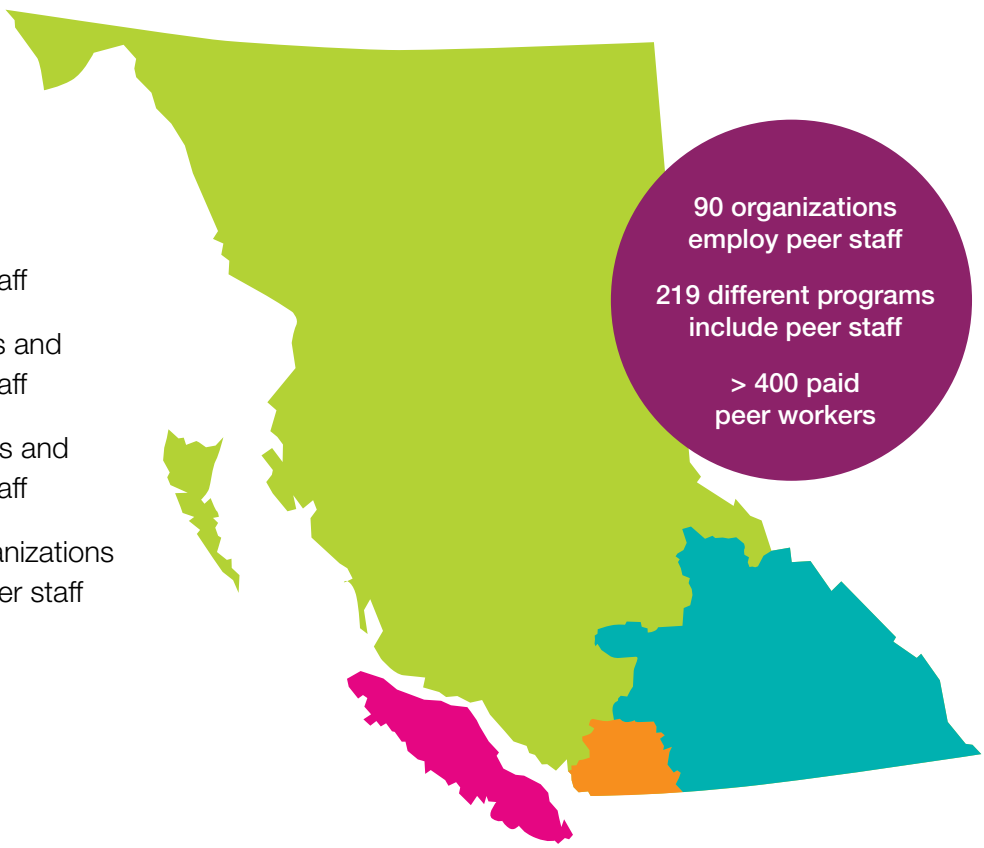
Where Peers are Working

In BC, the majority of peer workers are employed by health authorities or non-profit organizations located in the Lower Mainland and on Vancouver Island. The key findings from this snapshot are:

- The existence of a large and diverse workforce of peer workers in BC
- A provincial focus on harm reduction
- Near constant flux, with some programs ending and others beginning
- A concentration of positions and programs in urban centers
- Progress towards equitable employment that varied between sectors
- No centralized organization for peer support, connection, or advocacy
- Projects and programs operating in silos
- Staff shortages and restrictions due to Covid-19 filled by unpaid peer labour

Peer Employment by the Numbers

- **Lower Mainland:** 33 organizations and 89 programs with peer staff
- **Vancouver Island:** 24 organizations and 73 programs with peer staff
- **Interior:** 12 organizations and 25 programs with peer staff
- **Northern:** 9 organizations and 16 programs with peer staff
- **Province-wide:**[6] 12 organizations and 16 programs with peer staff

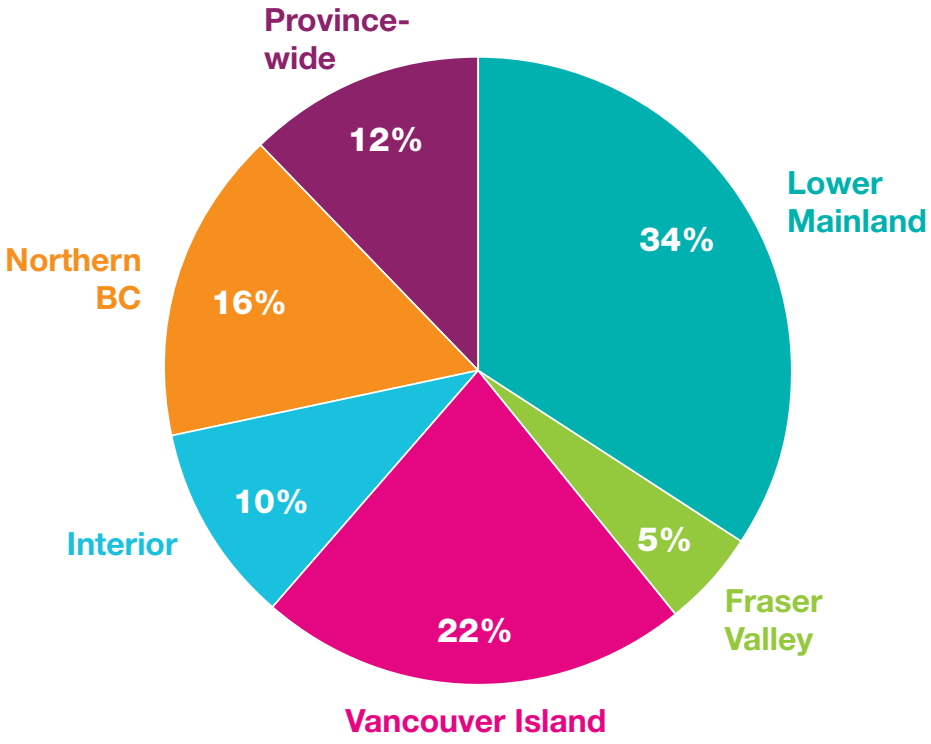


6 Organizations that offer online programs and have no centralized office open to the public.

What Peer Employment Conditions are Like

The Employer Survey aimed to understand current peer employment conditions. Of the 151 organizations who received the survey link, 59 responded. The respondents represented organizations from across the province. The Lower Mainland had the highest number of responses (34%) followed by Vancouver Island (22%); while fewer responses were received from Northern BC (16%), Interior BC (10%) and the Fraser Valley (5%). Respondents were primarily non-profit or community-based organizations (58%), then health authorities (24%) and peer-run groups (19%). The responses were compared to examine differences between regions and organization types.

EMPLOYER SURVEY RESPONSES BY REGION



Health authorities were found to offer greater job stability and compensation compared to non-profit organizations and peer groups. Non-profit organizations and peer groups were more likely to rely on honorariums for payment, offer fewer paid hours, and lack benefit programs. Similar differences were found between urban and rural areas; the further away from urban centers, the lesser the compensation and job stability for peer workers.

Key Findings from the Employer Survey[7]

Employment Status

Wages

Peer workers' payment types:

hourly (60%) honorarium (57%) salary (30%)

Wages range from **$15.50** to **$35** per hour.
Honorariums range from **$10** to **$50** per hour.

Peer workers' payment schedules:

biweekly (63%) inconsistent (42%)

Paid Leave

Most employers do not provide peer workers paid vacation time.

Paid vacation is provided only **40%** of the time.

33% of employers say **leave provisions** are dependent on peer workers' positions.

Only **30%** of employers provide **paid sick leave** to their peer workers; **37%** say **access depends on the position**.

Access to Benefits

Approximately **half (49%) of the respondents do not provide extended benefits** to their peer workers.

The other **half state that eligibility for benefits depends on the position**.

Most employers (**44%**) report that peer workers have access to mental health supports (e.g. **EFAP**, counselling, etc.), but **26%** do not.

The remaining **30%** say it depends on the peer position.

Recruitment and Training

The most common recruitment methods are **word of mouth or colleague referrals (79%)**.

44% of employers **hire program participants** AND

30% hire volunteers into paid positions.

Most entry-level peer positions have **no educational requirements (61%)**.

Some require an **equivalent combination of experience and training/education (26%)**.

Hours of work

Peer workers work an average of **13 hours per week** or **56 hours per month**.

The **majority work part-time or volunteer** (either unpaid or paid by honorariums).

Less than a third of employers offer full-time positions.

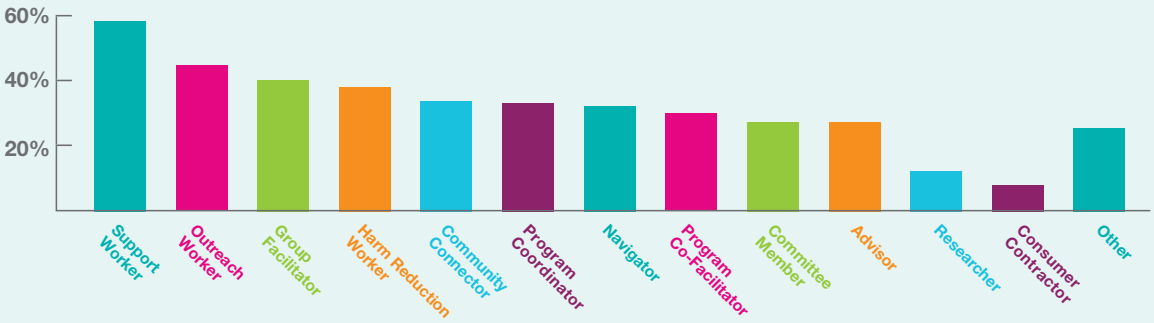
Most employers **(81%) offer flexible work hours**;

56% offer the option to work from home (partially due to COVID-19 policies);

46% offer access to quiet work areas.

7 Total percentages may exceed 100% due to peer workers holding more than one position at the same time, sometimes with multiple employers.

Position Type



The most common peer positions are support and outreach workers, which provide direct service delivery. Positions with greater potential for systems change, such as advisor and researcher positions, are less common.

Workplace Policies

Most employers **(77%) have policies/ guidelines to promote an equitable work environment** for people who use substances or identify a mental health concern.

Only about half of employers **(56%) have psychological health and safety policies**.

Only two employers **(3%) report requiring a proof of abstinence** from substances as a qualification for hiring.

Working Environment

About half of employers **(53%) give all peers access** to worksites (e.g., key cards), **24% give some access** (depends on position) and **23% do not give any access**.

Half of employers provide all peers work equipment and their own workspaces. **30% give access to some** (depends on position) and **20% do not**.

92% of employers provide paid on-the-job training.

How Peer Employment is Experienced

Over the course of four months (April to July 2021) 30 peer workers from across the province joined one-to-one interviews and a focus group conducted by our peer research team to share their experiences of peer work. To better understand the realities underpinning our map and survey data, participants were asked a series of open-ended questions on their employment history, work relationships, feelings of empowerment and disempowerment, and aspirations for the future.

Participants came from a diverse range of backgrounds. Of the 30 peer workers who were interviewed, 22 disclosed demographic information. Out of the 22 who disclosed, ten self-identified as White, six identified as First Nation, Métis, or Inuit, and one interviewee identified with each of the following demographic categories: Asian, Black, Hispanic and Pacific Islander. Four interviewees chose not to self-identify their race or ethnicity. Fourteen, a significant majority of participants, identified as women. Eight men and one **non-binary** participant made up the remainder of the cohort. Ages ranged from 18 to 65 years.

Most of the peer workers who participated had been employed for 1–5 years (45%). The rest had been employed for under one year (18%), 5–10 years (9%), or over 10 years (14%). A further 14% of participants chose not to disclose how long they had been employed. Participants represented a wide variety of job positions, levels of seniority, and geographic locations. The project team conscientiously selected an equal number of peers working in mental health, substance use, and combined MHSU-related jobs.

The experiences documented here are not representative of all experiences of peer employment. They provide a snapshot and some common themes that illustrate the challenges, rewards, and impacts of peer employment on peer workers themselves and the broader MHSU sector.

Aspirations for Equity Amidst Inequity

The central theme that surfaced across every interview was that social inequity and exploitation prevent meaningful participation and peer partnership. Peer workers often depend on limited-hour contracts and honorariums. Some stable and salaried peer positions exist, but most peer workers were sporadically or precariously employed and were forced to rely on public services (e.g., subsidized housing and social assistance) to meet their basic needs

Peers reported that many of their employers exploited their labour. They felt underpaid, reported a lack of traditional job protections, and experienced pressure to show up to meetings or for shifts on personal time without compensation. Despite the fact that many peers are told or perceive themselves to be independent contractors, they were often denied the opportunity to discuss or negotiate the terms of their work and consequently were paid low wages without job security, mobility, skills-building, or career advancement opportunities. One peer mentioned that at their worksite peers were often the lowest paid and the last to get paid because their roles were not integrated into the same payroll systems. Some peers also reported that their employers tended to rely on **volunteers** instead of paid positions.

> **"Peers I work with struggle with housing, food banks, and trying to live and make ends meet in a very low income [job]. It's very discouraging. It's hard to be optimistic, positive and upbeat at work when you're going through that. You're jeopardizing your own mental health by not taking care of yourself properly."**
>
> **– Peer participant**

The irregularity of pay and lack of job stability creates uncertainty for peers and further reinforces stigmatizing practices in the workplace. One peer who had a stable position felt fortunate, unworthy of self-advocacy because of this stability, and fundamentally unsafe when asking for higher wages. Other peers similarly expressed fear of hostility from their employer if they were to raise issues related to compensation. Peer workers often brought up how contract work felt particularly precarious because they were at risk of losing their jobs whenever the contract ended. Peers who received some form of income assistance reported that they were often afraid to report income because relevant income exemptions (e.g., **peer support work income exemption**) were not made clear and/or the

exemption process was unknown to their employer or even the Ministry of Social Development and Poverty Reduction workers with whom they interacted.

Many peers reported that they were paid significantly less than their non-peer colleagues (even though they sometimes performed the same duties) and worked on unpaid time. One participant shared that many peer workers face multiple barriers, economic instability, and limited job options so they end up accepting exploitative, precarious, and low-paying employment since they feel they have no other option. They suggested that many employers exploit these vulnerabilities and refuse to improve working conditions because they know they can get away with it.

Many of the peer workers encountered inequities between themselves and their non-peer colleagues. One peer said the most impactful inequities were the ones between housed and unhoused peer staff. Unhoused peer staff do not have the ability to show up to work in the same manner as housed peers because they may not have access to a phone, showers, sleep, or shelter, which contributed to their poor performance and less work being offered to them. Social inequities lead to the reinforcement of stigma that is often internalized by peers who then compensate by overworking themselves.

Peer workers often experience internalized stigma and felt the need to overextend themselves and perform above and beyond expectations to prove their worth. Some peers felt compelled to work extra hours and take on additional responsibilities, which resulted in high levels of burnout. Internalized stigma also manifested in some participants distancing themselves from other peers or holding themselves and other peers to a higher standard than their non-peer colleagues.

Peer workers who had secure work, livable wages, access to benefits, and union membership felt equal to other employees. At times, they even saw a reduction in harmful hierarchies and workplace power imbalances. These peers felt they could make choices about their life and work, maintain their health, and further their professional development. **Many peers reflected on the benefits they experienced including improved quality of life, the elimination of onerous healthcare costs, and the ability to leave income assistance.** Some peers mentioned that union membership gave them confidence that their jobs would not be terminated unexpectedly. The few peers who experienced financial security outside of work were not impacted by low wages or lack of stability and showed greater satisfaction with their role since pay was considered a bonus, not a necessity.

The Lived Realities of Peer Work

Many peer workers secure their first paid position through word of mouth. Often peers reported that their own service providers, support groups, or another peer they knew told them about the job and encouraged them to apply or recommended them to the employer. Others started out as volunteers at a site before eventually being hired. Some peers saw posters for peer training at facilities where they received services and enrolled in the training, which led them to complete a practicum and secure a job placement. A few of the peers we spoke to were able to create their own job opportunities by starting a peer-run organization or attending conferences and doing speaking engagements.

Many of the participants felt that there was not enough peer work, or peer positions in general, available for all the peer workers who wanted them. The work that was available was often limited to specific roles such as service delivery. There were less job options for peer workers who wanted to apply their skills and experience to other areas of the MHSU sector. Positions were often limited to short-term contract or casual roles. Although the flexibility of casual work was desirable for some, others who wanted full-time employment could not find any positions. Peer job opportunities were especially limited in rural areas, which led some peers to establish their own peer-led groups to provide better services to their communities. These peer-run organizations, however, often lacked access to permanent and stable funding.

> **"Some peers only want to work five hours a week. They like being contractors because it allows for that, and they have other sources of income. But others want it to be a career with a living wage and want to be unionized and employed. We need to offer a range of options to meet everybody wherever they're at. Someone might start as a contractor doing a few hours and then want to move up in the system, but we don't have many opportunities for that."**
>
> **– Peer participant**

After securing a position, many peer workers reported having unclear job expectations and being asked to do tasks that were outside the scope of their role and that they were inadequately trained for. These incidents exposed them to triggering, unsafe, and complex situations. Some peers mentioned that the training and supports offered at their worksites were insufficient for the realities of their work. Training often addressed simple topics that did not prepare them for the level of expertise necessary to support complex clients. Some of the peers we interviewed mentioned feeling a high level of responsibility for their clients but no ability to change or promote positive outcomes for them.

In the face of these issues, many of the peer workers we spoke to felt unable to advocate for themselves, set boundaries, exit uncomfortable or unsafe work situations, and/or access help from other staff. A few peers mentioned that they are often unable to reach other staff and did not know who to call during crisis situations or when they needed to debrief. Additionally, due to their low status in the workplace, peers often felt they could not advocate for better supports or changes without risking their already precarious positions.

Workplace Exclusion

Reports of exclusionary behaviour and policies frequently emerged in our interviews. At some worksites, peer workers on interdisciplinary teams were excluded from attending team meetings, which not only led them to feeling isolated, but also limited their access to critical information and impacted their ability to do their job. One participant spoke about how their non-peer colleagues had strong relationships and supported each other at work, but they felt left out because of their "peer" job title. Several peer workers reported a lack of access to other staff and not being included on team communications. Many believed that their exclusion was fueled by stigmatizing beliefs and stereotypes about mental illness and

substance use, as well as ignorance about peer roles. This was not the case at every work site. Some peers did report feeling included and valued at work and being invited to staff functions and meetings.

Several peers reported that they had limited access to basic workplace resources such as an ID card, keys to enter the building, and dedicated workspaces. One peer spoke about the impacts of not having their own designated office space and the challenges of having to constantly move around to different spaces that were not currently occupied. The daily shuffle made them feel uncomfortable and devalued at work and impacted their ability to do their job. Some participants we interviewed, however, reported they did have access to these basic resources and often felt more included, valued and respected at their work sites as a result.

> **"They [non-peer colleagues] support each other and they're connected in their little cliques, but as a peer support worker you're always a little bit on the fringe, on the outside periphery of that. I guess you're just not really included. Sometimes it's very obvious, like initially we weren't included in any staff meetings at all, and now there's talk that maybe we can be included in staff meetings, so there was a lot of information that was not made available [to us]."**
>
> **– Peer participant**

It was common among many of the peer workers we interviewed to feel devalued and underappreciated at work. One participant discussed how **non-peer staff viewed peer roles on the team as non-essential or as even being a favour to the peer.** Others commented on the lack of acknowledgment and recognition they received for their work.

Some peers felt that their perspectives and contributions were devalued because their workplaces did not consider lived experience knowledge to be as valid as other forms of formal education. Decisions were made without their input, often at meetings that they were not invited to, even when the decision directly affected their work. If peer workers were asked for their input, some reported that their opinions were ignored or dismissed if they did not align with the perspectives of management or non-peer staff, which led them to feel exploited and tokenized.

Several participants expressed concerns over the lack of peer representation at key decision-making tables within government and health authorities, especially when the matter was directly related to peer programs or MHSU service provision. In instances where peers were invited to these tables, some reported that their voices were still not heard and they often made similar comments over and over again to no avail. These issues made peers feel as though their role was unimportant and did not matter, which led to low-morale, high turnover, and resentment within the workforce.

Misaligned Values

Peers frequently experienced misaligned values while working within the hierarchical systems and structures that dominate BC's MHSU sector. Hierarchical workplaces were seen to go against the

basic principles of successful peer work, which is to establish non-hierarchical relationships and to have lived experience informing the service. Some participants reported concerns that the system overemphasized the medical model, which focuses on medication, biology, and treatment, instead of taking a more **holistic**, relational, and recovery-oriented approach to care.

> **"I started out trying to be me: the person that I am, trying to get anybody I can healthy and direct them to resources. But they shut me down, saying it had to go through their operation and procedure, and I don't know what their procedure is."**
>
> **– Peer participant**

The majority of participants expressed frustration because they knew what supports could help their clients, but they could not access them because of the inadequacy of some and the extreme lack of others such as shelters beds and housing facilities or detox and treatment facilities. One peer discussed the harms they witnessed from exclusionary policies in shelters such as those that would not allow clients to bring their belongings or their pets into the facility. Others felt their ability to be effective in their role was hindered by slow, bureaucratic structures and complicated logistics and procedures, which detracted from the more fulfilling human aspects of their job.

One participant felt that organizations often only include people with lived and living experience (PWLLE) in projects when it was necessary to receive funding, but they did not actually care about creating the necessary structures and safeguards to establish accessible, safe, and sustainable workspaces that support peer workers to fully participate. Despite these challenges and incongruencies, often peer workers' love for their clients and community was enough for them to continue to show up for a position that went against their better judgement. At times, this took an emotional toll and left peers feeling empty and unheard.

Identity and Intrinsic Rewards

Peer workers tend to have a deep affinity for their clients, work, and communities. **Many discussed how their work fed them spiritually, nurtured personal growth and learning, and enabled them to contribute to the healing of others, which brought them to a place of healing within themselves.** They felt a strong sense of purpose from peer work since they were able to use their experiences to have a direct positive impact on others. Peer workers who worked on teams that valued their expertise and contributions reported that their work brought joy and strength into their personal lives. There was a deep respect amongst teams who, despite coming from different backgrounds, were able to communicate often, learn from each other, and establish a collective understanding of their goals and purpose.

Many peer workers spoke about how they were drawn to this work from a deep place of empathy and their roles felt like an extension of their time in the community. The line between workers and clients, however, was often more blurred for peers working in environments where they were surrounded by and supporting their own communities. These peer workers discussed how setting and maintaining boundaries between themselves and the communities they lived and worked in was often complicated, created moral distress, and made it difficult to achieve a healthy work-life

balance. These participants felt that they were often left to personally fill the gaps of the MHSU system where services and resources were either not accessible or simply did not exist.

Cultural Safety

Some of the Indigenous peer workers we spoke to understood peer work to be a natural part of their culture that reflects Indigenous values of holistic wellness, relationships, and community. The concept of support extends beyond the person and symptoms of their illness to their physical, mental, spiritual and emotional well-being as part of an interconnected web of relations. Healing was described as a collective, multifaceted process, whereby a person's pain and wellness journey is shared by all their relations and community.

> **"There is a lot of value using the word "traditional" to describe these programs in different Indigenous communities—that's what we're ultimately trying to get back to, right? [A place] where every person had their place, everyone was connected to the land, the water, each other, animals, [and] the Creator. That's how our people maintained basic wellness and that's essentially what peer work is in our communities."**
>
> **– Indigenous peer participant**

Their holistic and relational understanding of wellness ran counter to the western concept of peer support. The emphasis placed on boundary setting, limits to self-disclosure, and building rapport did not resonate with some Indigenous peer workers. They expressed frustration about the inadequacy of the training and supervision they received.

> **"We come together in times of need; we come together in times of grief. At the heart of every community is peer work, that relationship to one another. First Nations people have endured a lot of trials and tribulations; colonialism was meant break us, so we're finding our way back to the heart of that work as a people."**
>
> **– Indigenous peer participant**

One Indigenous participant noted that their non-Indigenous supervisor failed to understand the cultural significance of a women's peer group that met every week for meals. More than simple nourishment and companionship, the group offered a space for Indigenous women to share teachings and come to appreciate their own power to collectively heal from substance use and regain their places within their communities. Their supervisor did not share the same vision.

Indigenous participants also shared stories of culturally safe and relevant peer work. One participant shared how their Naloxone training was more than how to administer the medication to reverse an overdose; rather it was a comprehensive education on the ongoing effects of colonialism, residential schools,

and intergenerational trauma that led to that moment. Another participant discussed the co-development process for an Indigenous peer support toolkit and reflected on the equitable collaboration between themselves, their employer and a consultant that centered their experiential and cultural knowledge. The process affirmed for them the importance of the work and instilled hope that peer work could contribute positively to Indigenous communities everywhere.

Professionalism

Traditional ideas of professionalism can conflict with all types of peer work. The necessity of peer positions to intentionally bring deeply personal experiences into employment requires a careful balance to avoid either retraumatizing or projecting one's own experience onto a client or the workplace. Some peers mentioned that for many people who have been mistreated by the system, the calm and diplomatic manner that is expected of professionals is harmful, but if they failed to model that demeanor, they were turned down for work.

> **"I would love for peers to do [more]; there's a lot of us that want to do so much work, but we don't have the education. And so, because without the education we can't move further, we can't move ahead."**
>
> **– Peer participant**

Many people we spoke to felt their workplaces not only did not provide the necessary training to navigate these complicated layers, but also lacked the ongoing support needed to keep a team healthy and functioning. Many peer workers hid on-going trauma, mental health difficulties, or relationships with substances to try and stay within those professional expectations, which often led to burnout, high turnover, resentment, and/or negative health consequences.

Peers who use drugs reported difficulty being authentic when working at abstinence-only organizations; some noted that **being open about their substance use could lead to their contract being canceled or hours halved, even when employed by organizations that openly sought peers with lived and living experience.** This double standard fostered stigma and created deeply entrenched hierarchies amongst those who use drugs and those who do not. Many peer workers who started with no prior professional experience relied on their team, and specifically other peers, to help guide them through this process.

Professional Development

The professional growth of peer workers is often limited. Peers brought up that they were unable to progress into more senior roles because of a glass ceiling for people who are labelled "peers" or those who lack a formal education. The lived experience peers bring to their work was reported as a roadblock because of stigma and preference for professional expertise. **Many pointed to the continued misperception that peer work is an extension of client-hood, rather than a legitimate career path.** Some peers were able to move up into roles with more responsibilities, better compensation, and the ability to implement and plan programming that benefited the communities they served, but this often required the support of non-peer staff and

buy-in from the organization for which they worked. Participants felt they were often at the whim of changing perceptions about peers and the value of lived experience, which dictated their progress or the scope of programming they oversaw. Many peer workers we interviewed were looking to move into adjacent work to advance their career since senior peer positions were in short supply.

Participants expressed a desire for additional training as they believed it would help to strengthen their skills and progress. While some peer workers spoke favorably of specific worksites that frequently offered training opportunities, others felt that they did not receive the same access to educational and professional development opportunities as their non-peer colleagues. High costs were cited as a barrier to accessing certification programs and attending conferences.

Several participants expressed the belief that peer workers could do a lot more in their roles but lacked access to affordable and appropriate training needed to get ahead. While some peer workers were seeking further training to improve their skills, many felt that further work needed to be done to improve the content and implementation of future training, as it was often developed and delivered without the input of peers, and as a result was less accessible and relevant. One peer suggested that a needs assessment should first be conducted to ensure the training is appropriate for the peer role.

Peer Leadership

Some of the peers we interviewed had reached a high level of success within their careers and took on leadership roles across the province, but most were still working in positions with very limited involvement in decision-making. A minority of peers were engaged at higher levels of their organization, led decisions at their worksites, and had access to large amounts of funding with substantial influence on policy and programming. A few of these peers were also on provincial boards with access to government officials and policy makers.

> **"I make my voice known, but I'm not in the position to make decisions. I know I have no say—we'll go with what you want to do, because what I say doesn't matter. That's basically how decisions are made."**
>
> **– Peer participant**

Many peer workers, regardless of their success, reached a point of frustration where they felt their influence was limited by their "peer" title. Even some of the peer workers who experienced continuous growth and success felt stifled after seeing first-hand the changes that needed to be made to the sector and feeling the lack of influence they had to make these changes. Peers who felt they had power in their role and over the programming they developed and delivered felt their ability to exert influence was at the whim of budgets, precarious funding, expendable peer positions, workplace politics, and potential vetoing by non-peer staff.

Peers who held management positions frequently reported feeling like their influence was limited by resistance to change within their organizations and the sector as a whole. Several peer supervisors

and managers gave examples of instances when they tried to make a positive change for their peer teams or programming, but felt unable to because they were either bullied, ignored, or met with attitudes of complacency and beliefs that "this is just the way things are" within their organization. Others reported that they felt the needs of their teams and their own needs were denied due to the lack of influence they had in the workplace. When peer managers were given little autonomy and flexibility over how they supervised their team relative to non-peer managers, they saw the negative impacts it had on everyone. Some participants reported that the entrenched hierarchies and levels of bureaucracy above them prevented them from making any meaningful change.

Lateral Violence

The scarcity of peer positions and the limited influence of peer leaders meant that members of the peer community expressed anger and resentment towards each other rather than at the systemic structures responsible for the inequity they faced. Some participants commented on the "old hats" that took up all the well-paid, influential positions and had financial motives to shut others out. Other participants commented on the disparities between peer workers and the desire to differentiate oneself from those whose health and life circumstances were much worse than theirs. **The unity often expected of a group of community-minded workers was at times fractured by the systemic pressures they endured.**

Peer Networks

Several of the peers we interviewed discussed the critical importance of having access to a robust peer network, yet many peers were still working within siloed workspaces where they had limited communication with other peers. Participants felt that peer networks or communities of practice would allow for skills sharing and mutual support that could only be provided by other peers who were doing similar work and experiencing similar challenges. One peer raised the issue that only unionized peers had access to a community of practice, but peers at other levels did not. Participants believed that greater access to such communities would provide a space that peers could use to debrief issues, brainstorm and share ideas, problem solve together, and organize educational events.

There was a clear increase in the influence of peers who were part of larger peer networks, whether these existed within their own organization or within the broader community. **Peers who were connected to a network expressed a much more positive attitude towards their workplace, job position, and ability to make positive change.** Several participants expressed the belief that peer networks help to amplify the voices of PWLLE and enable stronger collective advocacy to increase peers' influence in their organizations and the wider sector.

Some participants also discussed how peer networks help to address internalized stigma by providing a space with greater solidarity, mutual support, and value placed on lived experience. Peers reported that the hierarchies and rigid power structures common among other organizations are removed in this context. Several participants, however, were working within organizations or in jobs where they had limited interactions with other peers, which negatively impacted the potential for group advocacy and collective organizing.

WHERE TO GO NEXT

This section discusses the barriers to peer employment, equitable workplaces, and systemic co-production and offers recommendations to the Province of BC for reform.

> **"I was just a regular support worker and I feel that the problem with that is that the people who are identified as peer workers were making way less money despite doing the same amount of work as everyone else… People who weren't designated as peer workers were really hiding their drug use so that their pay wasn't cut in half."**
>
> **– Peer participant**

Removing Barriers to Employment

The most persistent barriers to peer employment and co-production are a scarcity of positions available to those who desire them and insufficient compensation. Peer workers can rarely support themselves on their wages alone, feel their positions are precarious or at risk due to factors outside their control, are forced to seek additional employment or other income sources, and are treated differently than their non-peer colleagues. While peers are an essential component of the MHSU workforce, peer work has no defined career path and is more commonly a stepping stone to other careers outside of or adjacent to the sector.

Financial security is a necessary condition for peer employment and co-production, but not sufficient. Peer workers, like all others, need a regular and adequate income. The exact payment of that income is the only aspect that may differ. Peer workers who have regular part-time or full-time positions may achieve financial security through a combination of compensation and benefits. Those who are casual workers may achieve the same security by receiving honorariums on top of other sources of reliable income such as disability assistance. Stability is subjectively determined but most commonly achieved when peers can maintain safe housing, are food secure, and can practice health management that extends to self-care, positive relationships, and community participation. The emphasis on stability rather than specific salary ranges, position types, or working arrangements reflects the diversity of the peer workforce who have differing needs and desires for employment. Peer workers occupy a diverse range of roles across the MHSU sector (2) but the vast majority deliver services (3) and are part-time employees or contractors. A recent BC survey of 200 peer workers across the MHSU sector found that only 26% reported full-time employment and 22% reported working in casual or volunteer positions. The peer workers who volunteered were significantly more likely to work for substance use organizations, identify as an ethnic minority, and/or not hold a university degree compared to the peer workers who had full-time employment or casual positions (12). Other studies suggest that non-standard work arrangements that are casual, informal, and short-term are the norm for many peer workers (5). These include meeting participation, consultation, and outreach services. Many peers similarly report sporadic volunteer work that involves completing one-off tasks for honorarium (5).

Research shows that insufficient pay and difficulties securing a livable wage remain one of the greatest and most common barriers faced by peer workers (3, 5–9). They

are often paid less than their non-peer colleagues (6, 10) and occasionally are the only people around the table who are not paid at all (11, 12). Inadequate compensation leads to greater financial stress and creates unequal power dynamics that lead to tension and resentment on multi-disciplinary teams (6). Since many peers are contractors or receiving honorarium, they are not eligible for benefits, must pay out-of-pocket for their health costs not covered by the public system, and are unlikely to be entitled to paid sick time above the legislated minimum (5). Peers who are regular employees and do receive benefits often refrain from using them due to fear of stigma and judgement and concerns over job and income security (7). The consequence is that many peers who live with disabilities and have higher than average health costs continue to experience financial insecurity regardless of their employment status.

The lack of full-time positions and the casual, short-term nature of peer work creates several barriers to the power sharing required for co-production. Many peer workers would prefer to work full time, but have difficulties obtaining sufficient hours (6, 8). The realities of searching for and managing multiple, minimal sources of income reinforces unequal power dynamics based on professional hierarchies and creates an environment of scarcity that either excludes peer workers from workplaces or undermines their ability to fully participate. **The only way to address this is to remove the necessity for peer workers to piece together a living wage and instead provide a stable foundation for financial security through public funds and targeted policies.**

What We Learned from Peer Workers

Peer workers repeatedly commented on the importance of financial security to meaningfully contribute to their workplaces and achieve equal standing to their colleagues. Many pointed to the lack of employment opportunities and the perception that they could be easily replaced by a dozen other peers who were vying for more work. The positions that did become available and offered some level of security provided too little compensation to meet their basic needs and necessitated supplemental income or access to public services. The few who had achieved financial security spoke of the empowerment they felt and the positive effect it had on all other areas of their life.

> **"I always like to see more peer support positions, and like more peer support workers. I would also like it to stay low barrier, but still be paid a livable wage; that's what people deserve."**
>
> **– Peer participant**

Livable Wages

Organizations that employ or contract peer workers offer a range of pay and benefits that could either support or hinder financial security. While some organizations did pay a living wage to the peers interviewed, other employers paid minimum wage and did not offer access to benefits. Many peer workers expressed a desire to keep peer work low-barrier, but wanted an increase in compensation to eliminate the need for other sources of income and better reflect the value of their contributions.

Wage Equity

Many peers reported that they were paid significantly less than their non-peer colleagues even if they performed the same duties. They also reported working on unpaid time. In some organizations, all other workers on a particular project or team were employed, while the peer workers were forced to rely on piecemeal honorariums. Despite such unfairness, few peer workers felt secure enough to voice their objections or advocate for equitable pay. **Many felt their employers viewed their inclusion as an act of charity and any sentiment other than gratitude would place them on a "blacklist" that would either bar them from future opportunities or lead to their dismissal.**

Earnings Exemptions

Many peer workers are on income or disability assistance and are fearful of earning too much and having their cheques clawed back, or worse, losing their disability status. Most received no information from their employer on income exemption policies such as how much they could earn without experiencing clawbacks and/or whether they qualified for and how to apply for the peer support work income exemption (4C payments). Those who did receive the peer support work income exemption commonly learned of the policy from another peer worker who had done the same. Many felt that receiving the information directly from their employer would have supported them to seek work without fear of losing income.

The themes raised by the peer workers we interviewed demonstrate the trickle-down effect of systemic inequity. Peer workers do not have an equitable opportunity to secure employment because of the scarcity of available positions and the precarious nature of them. Insufficient compensation undermines their ability to advocate for themselves for fear of losing what little they have. Those who have other sources of income, such as disability assistance, similarly fear loss of income which affects their decision to seek work. These issues can all be traced back to public funding and public policy that does not see the value and contributions of peer work.

> **"Being a peer worker doesn't have any of the things that a job has. Yeah, no cost of living increase, no advancement, no building of skills, none of those things. The wages are at the bottom of the basement and [there is] no real way to build hours."**
>
> **– Peer participant**

Discussion

Insufficient or Unsustainable Funding

Many employers have little choice but to use short-term, casual, low-wage contracts for peer workers because their funding is not guaranteed, and peer programming is often perceived to be inessential for staff and client services. Research, however, disproves this perception. Peers employed at health and community agencies increase accessibility and efficacy of a range of programs by creating an inclusive and welcoming environment, providing emotional support, supporting self-advocacy, and modelling hope and **recovery** (14). Stable funding is critical to ensure peer workers receive the same

compensation and benefits as other employees. **Dedicated funding from the Province of BC for peer employment would not only create equitable, sustainable jobs for peer workers, but also improve the uptake and quality of MHSU services.**

Peer compensation varies significantly across the province. In Northern BC, almost all of the employers we surveyed provided honorariums for peer participation. Hourly pay was uncommon and none of the employers offered salaried positions. Organizations that were province-wide or located in the Lower Mainland typically provided hourly pay and were less likely to offer honorariums, whereas those in the Interior and on Vancouver Island offered honorariums as frequently as hourly pay. Apart from province-wide organizations, salaried positions were rare across all regions.

Peer-run groups were most likely to rely on honorariums to compensate peer workers, whereas health authorities and non-profits or community-based organizations were more likely to offer hourly pay. Peer-run groups were also far more likely to report that their peer workers did not receive extended benefits, mental health supports, paid sick leave, or paid vacation time, though they recognized the importance of these benefits. Several survey respondents reported that they are unable to provide these benefits because of lack of funding since peer-run organizations face more inequities and barriers to accessing sustainable funding sources compared to larger community-based organizations and health authorities.

"The struggle to keep a peer-run organization afloat and diversify our funding is a real threat to our long-term future. Adding terms like paid peer opportunity and inclusive employment to already solid funding proposals, for delivery of quality services, seem to now hold little or no weight. Our leadership staff are forced to hold multiple job roles and are constantly stretched to their capacity. It would be nice to see peer organizations better supported, celebrated and resourced."

– Employer survey participant

Since 2017, the Province of BC has steadily increased spending on MHSU services. From Budget 2017 to Budget 2022, annual investments increased year-over-year to $375 million for the purposes of "advancing the expansion of services" (15). The plan for this expansion is *A Pathway to Hope*, a 10-year strategic policy document that aims to improve BC's mental health and addictions services (16). Included are numerous commitments related to increasing opportunities for and improving conditions of peer work across the province, providing funding and capacity building to peer-based organizations through the Provincial Peer Network, creating net new peer worker positions such as Peer Coordinators and navigator roles within health authorities to work with PWLLE, and developing Peer Worker Training Resources to provide to employers and post-secondary institutions and to enhance the quality and consistency of lived experience support worker training (15). Despite this, the Province's recent Health Human Resources strategy fails to mention the peer workforce and propose any actions to meet these commitments (17) .

Instead, these initiatives are silently funded from the larger $375M budget and allocated to a patchwork of health authorities and provincial organizations who then developed their own processes for distribution. While intended to support local responsiveness, minimal provincial oversight of the processes for determining eligibility and distribution has led to inequities and competition between organizations that undermine the very intent of strengthening the peer workforce.

> **"I don't like [the idea of] having one drug user group have the power to hand out and decide what other groups get money. [There] should be a committee of people from all different drug user groups who make those decisions and do the adjudication. It could happen that the board members of the one group chose only their own communities to receive funding or there's an issue with that one group and nobody will say anything because they're scared of not getting funding. It could really narrow ideologies to just that one group [sic]."**
>
> **– Peer participant**

Peer workers employed at peer-run organizations that are part of the Provincial Peer Network reported that a disproportionate number of resources were allocated to some groups at the expense of others and expressed frustration with the need to reapply for meagre funding year after year. The reliable, baseline funding they needed for operations was never offered. Peer employment at health authorities and non-profit organizations is similarly dependent on either annual assessment of operational need or specific grant streams that are tied to service delivery and often do not account for or underestimate the baseline costs of employment. While the exact percentage of Budget 2022's $375M that went to peer employment is impossible to determine, the amount itself, and the manner in which it was distributed, appears to be insufficient to adequately fund the peer workforce.

> **"It is very hard to follow the BCCDC guidance as a drug user organization. We have limited funding for so many programs we run, so to pay a person at $25/hour, we would have to cut our programming back significantly and have half as many peer volunteers."**
>
> **– Employer survey participant**

The first issue to address is the amount of funding. Provincial investments in peer employment need to expand the number of positions, provide sufficient wages and benefits commensurate to those paid to allied professions, and be benchmarked to inflation and costs of living. These calculations need to be regional. The employer survey clearly demonstrates that peer employment has not been equitably funded to-date. Northern BC and Interior BC should have the same opportunities to employ salaried peer workers as the Lower Mainland and provincial organizations. The only way to achieve this is dedicated, annualized funding tied to these conditions of pay equity between professions and across regions.

The second issue is the distribution of funding. There is no perfect way to do this, but meaningful partnership with a diverse and representative group of PWLLE or peer workers from the beginning to the end of the process can help avoid unintended inequities and help fulfill the intent of the investment. This consideration is especially important for Indigenous peer positions and organizations. In order to fulfill the Province's commitments under the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA) and "increase the availability, accessibility and the continuum of Indigenous-led and community-based social services and supports that… address a range of holistic wellness needs," control of funding should be handed over to First Nations, Métis and Inuit communities, both urban and on-reserve, who can determine for themselves what peer employment should look like for them. Our interviews clearly indicated that western practices of peer support based on biomedical models of mental illness are incompatible with Indigenous ways of knowing and healing and should have no bearing on the allocation of resources for the Indigenous peer work force.

Perception of Precarity

Many peers who work for health authorities or non-profit organizations perceive themselves to be independent contractors because of their temporary or casual positions, ineligibility for benefits and union membership, and/or their practice of invoicing for hours rather than completing timesheets. Their perception often leads them to believe they have no rights and are not protected by provincial employment standards, leading them to fear taxes and Canada Revenue Agency (CRA) audits. The pressures of poverty, and for some, substance use, are layered onto their experiences of exploitation to disempower and dissuade them from advocating for themselves.

The reality is most individual peer workers who are contracted by a health authority or non-profit organization may actually be in an employment relationship that entitles them to basic standards of compensation and conditions guaranteed under the *Employment Standards Act* (the **ESA**).[8] The ESA applies to non-unionized employees regardless of whether they are employed on a part-time, full-time, temporary, or permanent basis. The primary exception is independent contractors who are not covered by the ESA because they are deemed to be self-employed. The difference between an employee on a temporary contract and an independent contractor can be difficult to distinguish, but factors to consider include the extent to which the worker exercises direction and control over their work, operates their own business, has their own clients, has a chance of profit or a risk of loss, and maintains an ongoing relationship with their employer (18).

On almost all of these factors, peer workers would likely be considered employees. For example, peer workers who provide one-to-one or group support to clients are given specific directions for the performance of their job duties and are required to adhere to employer policies. They are rarely granted the autonomy to respond to clients' needs based on their own knowledge and are beholden to organizational policies or the professional boundaries set out by their employer. They do not set their own fee or compensation, operate their own business, have their own clients, are not at risk of losing or gaining profit outside of the wages they earn for hours worked, and many stay "on contract" with the same employer for years.

8 The Employment Standards Branch, which administers the *Employment Standards Act*, can answer general inquiries or provide confidential support to workers about their work situation. For contact information, visit: www2.gov.bc.ca/gov/content/employment-business/employment-standards-advice/employment-standards/contact-us

As employees, peer workers may be entitled to some standardization around work hours, overtime hours, meal and coffee breaks, annual vacation, paid sick time, and job protected leaves of absence such as illness or injury leave (19). Peer workers can file a complaint should their employer not fulfill their obligations under the ESA, but many are unaware of their rights or feel their jobs are too precarious to exercise their rights. **While understanding and exercising employment rights may help to lessen the job precarity of peer workers, the application of employment standards will not remove the persistent barriers of insufficient public funding and outdated income exemption policies.**

Peer Work and Social Assistance

Many of the peer workers we spoke to are on income or disability assistance and are unaware of an existing legal exemption within income and disability assistance regulations that may support them to retain some or most of their peer employment income. Increased awareness and access to this peer support work exemption could help peer workers increase their monthly income, reduce their fear of clawbacks, and/or ameliorate their hesitancy to seek employment; however, employer uptake is sporadic. Some are unaware of the policy, others may not qualify, and many may hesitate to extend the policy to their peer employees because the intent and scope of the policy is unclear.

The legislation and policy manual that governs BC's social assistance system states that "payments to a person with a mental disorder who provides formal or informal peer support" are exempt from assistance deductions if their employer is a designated agency that "has been approved by a health authority to provide services on its behalf." (20) An employer can investigate whether or not their organization and peer staff qualify for an exemption, but many are unaware the policy even exists, and information on how to become a designated agency is not publicly available. In our employer survey, only 32% of respondents provided letters of exemption to their peer workers on disability assistance, which is the standard means of confirming the exemption. The remaining employers either did not provide a letter or simply did not know if they did or what the exemption was.

The lack of awareness by employers is mirrored among Ministry of Social Development and Poverty Reduction (the 'Ministry') workers. Peer workers sometimes refrain from claiming the exemption, even with documentation from their employer, to avoid interactions with Ministry workers who are often unaware of the exemption or enforce specific requirements for the documentation that are difficult to obtain.[9] The exact exemption code (4C) may be missed, misunderstood, or prompt questions that may affect the reliability or amount of assistance a peer worker receives. At present, the most reliable method for obtaining the exemption is for peer workers to provide their employer with a decades-old paper template to sign,[10] then for the peer worker to scan and submit the signed copy to the Ministry online or by mail. An alternative option is for the employer to write a brief paragraph that confirms the peer worker's employment and the nature of their duties.

9 It is important to note that reluctance to contact Ministry workers is not limited to this issue. Participants shared that they are often afraid to contact Ministry workers because of prior mistreatment and often felt unsafe when requesting information about their assistance payments, never mind asking for an exemption.

10 See Appendix 1: Sample peer support worker letter in the BCCDC's guide for paying peer research assistants found at: paninbc.ca/wp-content/uploads/2016/05/A-guide-for-paying-peer-research-assistants-challenges-and-opportunities.pdf

Even if awareness improves and eligibility for designated agencies is expanded, many employers may not pursue the exemption because of the policy manual's outdated definition of "peer support" that does not reflect the job duties of many peer positions. The policy manual states that payments that are not considered income and are exempt from income assistance deductions are for "formal and informal peer support" and "participating in the Therapeutic Volunteer Program" (20). There is no mention of advisor roles, outreach, harm reduction, research, or any of the other myriad paid positions that exist across the MHSU sector. The policy manual needs to be updated to include a broad range of peer work.

An argument could be made that peer employment is employment and any income earned should count towards a person's annual **earnings exemptions** and be subject to deductions above the legislated maximum. In BC, a single person receiving income assistance can earn up to $600 per month and a person on disability assistance can earn up to $16,200 per year (20) before deductions.[11] These amounts, when added to the monthly payments of $1,060 for income assistance (21) and $1483.50 for disability assistance, (20) are below the poverty line.[12] The latest Market Basket Measure (MBM) for BC, based on cost-of-living calculations for 2020, ranges from $43,069 per year for rural areas to $50,569 per year for Vancouver (22). Those on income assistance who earn the maximum amount allowed have an annual income of $19,920, while those on disability assistance who earn the maximum amount have an annual income of $34,002. The discrepancy between the MBM and the annual income of those on assistance reinforces conditions of poverty.

Inadequate assistance rates aside, the argument for deductions above the annual earnings exemption ignores the fact that a core component of a peer worker's knowledge and skill set comes from their drug use and/or mental health condition. These aspects of their identities are often discriminated against in the broader job market and can at times place health-related limitations on their ability to work. The income assistance claw backs not only disincentivize people from accepting the few employment opportunities available to them, but also unfairly penalize wellness and economic participation. In no other job would someone fear a loss of income because they worked too many hours or face penalties for possessing the very experience necessary for them to do their work. Peer workers on income and disability assistance should qualify to receive the exemption and all employers of peer workers should be eligible to offer the exemption. Employers should further receive education on how to offer the exemption to those who are eligible.

11 These figures reflect changes announced to rates and exemptions announced in BC Budget 2023, effective July 2023. BC Budget 2023 announced an increase in earnings exemptions of $100 per month for income assistance recipients and $1,200 annually for disability assistance recipients ($600 per month and $16,200 per year, respectively).

12 The monthly payment amounts are for single persons and include the shelter allowance, which as of July 2023 went from $375/month to $500/month. It is important to note that the shelter allowance is sometimes paid directly to landlords and that persons who are homeless or considered dependents are not eligible for the amount.

Recommendations

We recommend the **Ministry of Social Development and Poverty Reduction**, in partnership with the **Ministry of Health**, consider enhancing access to the peer support work income exemption for all peer workers in BC by:

a. Expanding eligibility for the income exemption from only peer support work to include all types of MHSU peer work where lived and living experience is a qualification for the position and necessary for the performance of job duties;

b. Developing a clear way of accessing and systemic way of processing the peer work income exemption, including eliminating the need for peer-employing organizations in the MHSU sector to be "designated agencies" through a health authority;

c. Developing educational resources for employers on how to facilitate the exemption for peer workers who are on income or disability assistance; and

d. Working with community partners to co-develop and distribute resource materials to peer workers to understand their eligibility and process for applying for the exemption.

We recommend the **Ministry of Health**, in partnership with the **Ministry of Mental Health and Addictions**, consider continuing the work that began in *A Pathway to Hope* to increase opportunities for peers and improve peer work conditions within the MHSU sector by:

a. Recognizing **peer support workers** in the Health Human Resources (HHR) Strategy, which includes MHSU services as a priority area;

  i. For example, the Ministry of Health could include peer workers in the new employer-sponsored 'Earn and Learn' programs (Action #53 of the HHR Strategy), to reduce financial and other barriers to training and offer viable career growth opportunities for peers who want and are in a place to grow their careers;

b. Mandating that any paid peer positions in the MHSU sector funded by the Ministry of Health or the Ministry of Mental Health and Addictions, either directly or contracted through partners (e.g., health authority, community-based organization), are provided a liveable wage and benefits on par with similar non-peer positions, and;

c. Creating a funding stream exclusively for peer employment that is accessible to health authorities, non-profits, and peer-run organizations that are part of the MHSU sector. Employment conditions such as a liveable wage, benefits, and providing the income exemption should be mandatory eligibility criteria to apply for and receive the funding, which should be reviewed annually and be provided on a recurring, annual basis to organizations that continue to meet the conditions.

Creating Equitable Workplaces

Workplaces are often built on hierarchies. In health and social service settings peer work is commonly placed at the bottom of a tier of professions and devalued based on prejudicial beliefs about the value of lived and living experience relative to the value of formal education and credentials. Inadequate wages are often the hallmark of this, but the experiences run much deeper. Peer workers

face social exclusion, stigma, discrimination, and inequitable access to staff resources and benefits. To truly practice co-production, workplaces must examine their hierarchical structures and the biases that reinforce these structures, and actively attempt to dismantle them and rebuild based on equitable partnership that places peer and non-peer colleagues on equal footing.

Peer workers apply their diverse skills and expertise to a wide range of peer positions that encompass a variety of job duties (1, 2) such as providing support and direct care (3, 12), harm reduction services (5), education and knowledge exchange (6, 7), service and system navigation (26), research (12), advice on policies and programs (5, 9), and supervision of other peer workers (28). Role clarity is a significant issue that impacts the equitable inclusion of peer workers in the workplace. Often peer worker roles, responsibilities, and expectations are not adequately communicated to them or other employees (29). Without a clear understanding of their role, peer workers find it difficult to know how they can draw upon their knowledge and expertise to accomplish tasks (10, 12). They frequently report that their supervisors do not give them enough autonomy, are too intrusive (2), or treat them differently than their non-peer colleagues by restricting their work and limiting their ability to contribute (30).

Relationships between peer and non-peer staff are similarly significant for the creation of equitable workplaces (15). A study by Burr et al. found that all factors for peer inclusion are relational and include face-to-face communication, openness, respect, and "humane" contact (17). Peer workers, however, are often left out of spaces where relationship building takes place such as work gatherings, meetings, and team activities (3). This physical separation reinforces experiences of exclusion. Many peers consequently report feeling isolated and separate from their colleagues (3) and these feelings are further worsened by experiences of stigma and discrimination (5, 10).

Prejudices and discriminatory attitudes from non-peer staff are considered by many peer workers to be an ordinary part of peer work that reinforces exclusion (5, 10). Mental health professionals have been found to be uncomfortable interacting with people who experience mental illness, including peers with whom they may work (34). A perception persists that peer workers are "patients" or "pseudo staff," which leads to an "us" and "them" dichotomy that undermines interpersonal connection (10) and creates a fundamental disconnect between peer work and other forms of mental health care. Many peer workers rightfully fear their work being

"They've rationalized it that we are 'receiving a service', but we aren't receiving anything. We're just doing a job and getting paid. We're not being trained, mentored, led or taught—we're just being put out there. What service are we receiving in lieu of better pay? We're not receiving anything. They've just got this group of vulnerable people [who] they're paying nothing out there keeping tabs on people [who] are doing worse. They couldn't rationally pay people [this little who] didn't have lived experience; they would advertise the job on LinkedIn and they'd get nobody."

– Peer participant

absorbed into the mainstream mental health system (1, 8). Studies have shown that they risk losing the ideals of mutual support, such as equal relationship and authenticity, that are incompatible with the traditional medical model based on the hierarchy of practitioner to patient. Some peers are documented to believe that the values of authentic peer support are diminished when non-peer staff determine their roles and responsibilities (12).

Workplaces that are not strengths-based lead to feelings of dissatisfaction and disconnection amongst peer workers (10). Participants of various studies have reported feeling conscious of how they are viewed by non-peer staff because of disclosure of their mental health status (30). Many found it difficult to raise concerns about their workplace since they fear their behaviours may be attributed to personal traumas and not seen as real challenges that arise during the course of their work. Such fears were substantiated by a survey that found that over half of the respondents witnessed their non-peer colleagues speaking disrespectfully about certain mental health diagnoses and almost 60% felt their work conditions were markedly different then their non-peer colleagues. These issues lead to shorter tenures for peer workers because their workplaces became unsafe and their health suffered (30).

Peer workers not only experience the stress of exclusion, stigma, and discrimination, but also lack access to benefits and accommodations that would support them to cope and help to address any underlying disability-related needs that limit their full participation. Access is often restricted due to non-standard work arrangements, and even those who do have access often refrain from requesting accommodations or using paid sick time due to fear of stigma or concerns over job security (28). The need for accommodations is ironically linked to adverse working conditions. Byrne et al. found that **while there are concerns that peer workers will often require more accommodations, often none are needed when workplaces are adaptable and offer appropriate supports** (35).

Workplaces need to do more than accept peer workers by clarifying their roles and inviting them into spaces formally barred to them. The professional hierarchies that structure the MHSU sector must be dismantled and principles of mutual support and lived and living experience must be held in equal esteem to clinical protocols and professional credentials. Both are lofty goals, but change can be initiated amongst staff. Non-peer staff can learn about peer work and unpack their own biases to promote greater inclusion. Employers can provide equitable access to benefits and accommodations to eliminate structural exclusion. These steps will lead to greater retention, tenure, and respect for peer workers whose mere presence is a necessary first step towards equitable partnership for longer-term systemic reform.

"While my place as a person with lived experience was being honored, that role was, in essence, very limited. After about 1.5–2 years, I hit a glass ceiling. My feeling was "okay, we love what you're doing, we want you to keep doing it, but don't come up here with us."

– Peer participant

What We Learned from Peer Workers

Peer workers repeatedly commented on their experiences of workplace exclusion that were based on a misunderstanding of peer work and a fundamental misalignment, or at times contradiction, between peer work and other

forms of mental health care. **Many peers felt tokenized or exploited because their workplace added peer positions, but otherwise remained the same and failed to accommodate them.** Some workplaces held rigid notions of "illness" and "professionalism" that perpetuated stigma and prevented peers from truly fulfilling their roles. Other peers had different, more positive experiences and noted the impact of flexible and adaptive workplaces on themselves and their colleagues.

Working Conditions and Expectations

Many peers reported unclear job expectations and exposure to triggering, unsafe, or complex situations that fell outside of their skillset. Some peers mentioned that the training and supports at their worksites were not sufficient for the reality of the work they were doing. Others mentioned feeling a high level of responsibility for their clients but having no ability to change or promote outcomes for them, which limited the efficacy of their role and perpetuated misunderstandings about the value of peer work.

Overreliance on the Medical Model

Hierarchical workplaces were seen to go against the basic principles of successful peer work, which is to establish non-hierarchical relationships and provide mutual support (see comparison chart on the next page). Some participants reported concerns that the system overemphasized the medical model, instead of taking a more holistic, relational, and recovery-oriented approach to care. Such emphasis leads to valuable programming being under-funded or cut, which was seen by one participant to signify the mainstream mental health system's reliance on temporary band-aid solutions, instead of interventions to address underlying systemic issues that lead to MHSU issues.

MEDICAL MODEL VS. PEER SUPPORT

Peer workers repeatedly commented on the discrepancy between their understanding and treatment of mental illness and substance use and that of their non-peer health care colleagues. While we did not directly ask about such discrepancies, some commonalities or themes became apparent indicating radically different values, relationships, practices, and outcomes between the two professions.

	TRADITIONAL MEDICAL MODEL	PEER SUPPORT
VALUES 	• Prevention of death • Health promotion	• Hope and recovery • Empathetic and equal relationships • Self-determination • Dignity, respect, and social inclusion • Integrity, authenticity, and trust • Health and wellness • Lifelong learning and personal growth
RELATIONSHIP 	• Hierarchal—medical practitioner possesses superior knowledge to treat the patient who is unable to help themselves and dependent on the medical practitioner to fix the underlying health issue	• Mutual—peer supporter and the person being supported are equal to one another and relate to each other based on shared living and lived experience
PRACTICES 	• Diagnose the cause of the person's distress based on clinical criteria and assessment • Develop a treatment plan based on medical knowledge, often includes a combination of pharmaceutical and therapeutic interventions • Schedule regular appointments to monitor compliance with treatment plan and progress towards symptom reduction • Discharge a person from care when symptoms have reduced	• Listen to a person's mental health journey in the context of their life and provide emotional support by empathizing and relating based on shared living and lived experience • Provide practical support by helping them to identify their goals for recovery and develop plans for achieving them • Meet regularly to provide encouragement • Inspire hope by demonstrating that recovery is possible • Continue the peer support relationship until the person decides to discontinue
OUTCOMES 	• Symptom reduction	• Personal empowerment • Self-reliance and efficacy • Self-defined recovery

Behavioural Norms

Some peers came to this work having limited professional experience and were given insufficient mentorship or training to understand certain expectations for behaviour. The traditional boundaries that they learned were part of being a "professional" were counter to peer work, which relies on personal sharing, humility, and commonality. The peers we spoke to often felt conflicted about how to behave towards their colleagues and perform their job duties. The vulnerability and authenticity they brought to their work often ostracized them from their non-peer colleagues, but upholding standards of professionalism undermined their ability to provide support and connect with clients.

Stigma and Discrimination

Participants reported experiencing stigma and discrimination at work where harmful stereotypes about people who have a mental illness or use substances were perpetuated, such as PWLLE being unreliable and untrustworthy. The impacts of this were felt by many of the peers we spoke to who believed they were often treated differently than non-peer staff due to stigmatizing attitudes, beliefs, and stereotypes. Other staff can experience dismissive attitudes from colleagues when struggling to fulfill their job duties, but peers found that any indication of struggle was attributed to their mental health or substance use and that stigmatizing assumption often meant the actual reason (such as time management or lack of safe housing) was never addressed or even acknowledged. Most reported being excluded from decision-making and felt that they were the least valued member of their team.

> **"Some of the things that create a good environment are maintaining open communication between the team, having regular team meetings, and putting the leadership of decision making into the hands of my team members as much as possible. My approach with the team is to say 'this is the broad expectation of your role, this is what we do, here's the work I need you to do; how you do it is creatively and individually up to you'. I give a lot of leeway to self-directed work."**
>
> **– Peer participant**

Adaptive and Flexible Work Environments

Some peers we interviewed spoke positively about the flexibility that their workplaces offered. In particular, they reported that they could adapt or adjust their roles to match their abilities, including being able to work flexible hours and take time off when needed, or if necessary, access programs like long-term disability. One participant discussed how this approach increased the equitable inclusion of peer workers by allowing them to pick up shifts as needed and effectively contribute when well. The extension of such flexibility to all employees meant that peer workers did not have to ask for accommodations and risk discrimination or justify their needs and perpetuate stigma. These peers reported feeling equal to their non-peer colleagues and valued for their lived experience.

Discussion

Social Inclusion at Work

Our employer survey backed up the findings from our peer worker interviews and demonstrated that both exclusion and poor integration of peers within multidisciplinary teams are common across BC. Although the majority of the employers we surveyed indicated that peer staff attended and contributed to team meetings, 11% still excluded peers and effectively barred them from connecting with colleagues and accessing critical information. In addition, many of the employers we surveyed (32%) reported that non-peer staff do not receive information on the role of peers, despite this being vital for staff to understand the value and importance of their contributions. This limited information sharing was reported more often by health authorities and was less common among non-profits and peer-run groups.

> **"I have felt discriminated against. In certain circumstances, I felt like I didn't receive the same level of access to training, information, and communication that somebody who wasn't a peer worker would have."**
>
> **– Peer participant**

The first step employers can take to promote greater inclusion at their workplace is to clearly define the roles and responsibilities of peer workers and communicate the details of their positions to all employees. While role delineation may seem obvious, many peer workers reported often not knowing the boundaries of their role or felt the boundaries were blurred. Since peer workers themselves often cannot articulate their role to their colleagues, those who are not peers may (and often do) fall back on stereotypes or biases based on personal experiences, media, and public discourse. The employer can prevent this and combat prejudicial beliefs about peer workers' capacity and contributions by simply stating and clarifying what peer work is and is not. The neutrality of the communication and the organizational power of the person who issues the communication can lead to subtle shifts around the visibility and value of peer work.

Still, stigma is likely to remain a significant barrier to equitable employment. Research consistently demonstrates that prejudicial attitudes towards mental illness persist among mental health professionals, and anti-stigma education is necessary to improve health care relationships (36). An integrative review by Carrara et al. found that anti-stigma interventions that facilitate social contact or direct personal contact between healthcare providers and members of a stigmatized group are most effective at long-term stigma reduction, especially when they target specific topics and provide post-intervention follow up (37). Pinfold et al. similarly concluded that the key active ingredient of anti-stigma programs for mental health is the testimonies of service users (38).

The emphasis on social contact or service user testimonies across the literature begs the question: why do mental health professionals who regularly interact with and care for people who are living with mental illness hold onto stigmatizing beliefs? In their paper on considerations for combating mental illness stigma, Ungar et al. posits that one possibility is that health care professionals only

see persons with mental illnesses when they are unwell, which leads them to develop a biased view of mental illness that discounts the possibility of recovery. Another possibility they put forward is that the service relationship is inherently unequal. The authors recommend not only "contact-based" interventions similar to other researchers, but also emphasise inclusion of recovery-oriented principles and "client educators" or peer workers to lead the education programs and exemplify recovery. (39). The repositioning of PWLLE from patient to educator is critical to reversing and then equalizing the power imbalance between health care professional and patient. The same principle is likely to apply to the employment relationship.

The next step for employers to promote equitable inclusion is to provide anti-stigma education for all their staff. A challenge is that most anti-stigma programs focus on particular mental health diagnoses or substance use-related behaviours, rather than peer work and the workplace. New programs are needed to address not only mental illness and substance use stigma, but also the role and value of experiential knowledge, risks associated with re-traumatization in the workplace, and strategies to foster a trauma-informed work environment. The latter components are particularly important for organizations that employ Indigenous peers or serve Indigenous people. A broader curriculum should address the ongoing harms of colonialism, culturally safe practices, Indigenous concepts of holistic wellness, and principles of self-determination.

BC Campus currently offers a training module for employers that includes education on the ladder of engagement, importance of language, importance of role clarity, peer networks, compensation, job descriptions, income exemption, peer payment standards and MHSU support (40). While this practical guidance is necessary, the one-time, online course does not address the underlying beliefs and prejudices that inform and perpetuate workplace hierarchies, and while co-developed with peers, does not offer evidence-based or interactive methods for delivery that allow for in-person contact with peers.

New anti-stigma education focused on the contributions of and conditions for peer work will help to break down negative biases and build employer capacity to establish an inclusive, safe work environment that fosters mental wellness for all staff. In keeping with the evidence and principles of co-production, the programs should be designed, developed, delivered, and evaluated by peer-based and Indigenous-led organizations that incorporate diverse perspectives across the spectrum of MHSU peer positions and experiences.

Workplace Accommodations

Mental health conditions and substance use disorders are both disabilities that constitute protected characteristics under the BC Humans Rights Code ('the Code'). Employers have a duty to accommodate employees and persons applying for jobs by addressing workplace barriers that arise due to characteristics protected by the Code (41). Accommodations are typically made in response to an employee request, but peer workers report a hesitancy to seek accommodation due to stigma and fear that their employer and colleagues will believe them incapable of performing their job because of their disability-related needs. Accommodation will become accessible only after employers have addressed workplace stigma and promoted equitable inclusion through communication and education.

In workplaces where accommodation is accessible, what does it look like for peer workers? In their employment equity toolkit, BC's Office of the Human Rights Commissioner (**BCOHRC**) outlines seven types of accommodation: modifying the work environment, modifying job responsibilities, modifying workplace policies, providing supportive personnel, flexible scheduling, providing assistive technologies, and exchanging statutory holiday for another day off (41). The applicability and specificity of each accommodation will vary according to the disability-related needs of the peer worker, their job duties, and their work environment. The most common workplace accommodations were flexible hours and locations, as well as paid time off for illness and medical appointments.

Peer worker disabilities can intersect with other aspects of their identity and compound experiences of discrimination. For example, a racialized or Indigenous peer worker may encounter prejudicial barriers based on their race or Indigeneity and mental health or substance use-related disabilities. Often accommodations fail to account for the intersectionality of employees' identities and experiences, and therefore seek to overcome one barrier while reinforcing another. To follow from the previous example, accommodations for substance use may entrench harmful stereotypes about Indigenous people being "addicts" or "alcoholics" and leave a peer worker more vulnerable to racism.

Active substance use is another added complexity. Peer workers who use substances often encounter discriminatory workplace policies and hide their use for fear of repercussions. Although only two of the participating employers reported that a proof of abstinence from substances was required for hiring peer positions, the practice is still frequently reported in the literature. Some peer employers require abstinence and conduct drug testing to determine whether a peer worker has used substances (40, 41), while others go as far as to prohibit them from accessing substance use services such as safe injection sites at their organization (31). These exclusionary policies serve to single out employees who use substances (40, 41) and drive them to hide their use due to fear of discrimination and job loss (31).

Another Reflection on Co-Production

Many workplaces have discriminatory policies that may pose barriers to employing peer workers—CMHA BC was no exception. The personnel policy manual includes a section on substance use and addictive behaviours that prohibits the consumption of "alcohol, illicit drugs or medications other than prescribed" during working hours and states that those who breach this policy are subject to "discipline up to and including the termination of employment." The prohibition on drug use, alongside a well-intentioned provision to support access to abstinence-based treatment and rehabilitation, was a barrier to employing peer researchers who use substances.

The advisory committee was clear that both lived and living experience were valuable and necessary for the project. I knew I could not change the policy overnight and had to figure out another way: **accommodation plans**. Since substance use disorders are disabilities and protected under the BC Human Rights Code, I could write an accommodation plan for the peer researchers who use substances that exempted them from the policy. In addition to overcoming this barrier to employment, the development of the accommodation plan with the newly hired peer researchers created an opportunity for us to discuss the concept of "fitness to work" and paid sick time, and to establish a flexible working environment.

Since *living* experience of substance use is a necessary qualification for some peer positions and substance use-related disabilities are protected under the Code, employers cannot prohibit all forms of drug use while at work. WorkSafe BC encourages employers to develop policies and procedures that address impairment rather than enforce abstinence (44). In their best practice manual for supporting peers/experiential workers, the Peer2Peer project expands on this concept of impairment and defines the concept of "fitness for work." Peer workers are expected to perform their job duties, determine their own ability to work, and communicate to management when they feel unable to work. Employers are advised to be cognizant and tolerant to physical reactions of drug use that do not compromise health or safety (such as sweating or enlarged pupils) and intervene only when behaviours related to fatigue, irritability, disorientation, inability to communicate, or erratic movements put the peer or other employees at risk (43). The shift from prohibition to health and safety for all staff can help to eliminate the practice of singling out and disciplining peer workers for their drug use.

The Peer2Peer concept of "fitness to work" demonstrates a preventive response to discrimination. While accommodation is based on an individual employee's disability-related needs, workplace policies apply to all employees and create a more inclusive environment that removes the onus on the employee to request an accommodation and discuss their illness or substance use with their supervisor or employer. A truly equitable work environment would offer peer and non-peer staff the autonomy to determine their own fitness to work and the flexibility and benefits to work only when they are well.

Recommendations

We recommend the **Ministry of Mental Health and Addictions** consider dedicating funds for a peer-based or peer-employing organization to develop and deliver training to MHSU organizations on the role and value of peers in the workplace, the risks associated with re-traumatization in the workplace, and strategies to foster a trauma-informed and stigma-free workplace. The training could include components by and for Indigenous organizations that address the ongoing harms of colonialism, culturally safe practices, Indigenous concepts of holistic wellness, and principles of self-determination.

We recommend the **BC Office of the Human Rights Commissioner** consider expanding their current guidelines on employment equity to include examples of accessible workplace practices and intersectional accommodations that employers can enact and offer employees to increase inclusion of diverse persons who have mental health and/or substance use-related disabilities. The guidelines should specifically address peer workers, where the nature of their role may require them to disclose at least the existence of a health issue or disability or an aspect of their identity that is often subject to discrimination, and provide guidance to employers on the fulfillment of human rights obligations.

Building Toward Co-Production in BC

Imagine a workplace where peers are provided adequate wages and benefits commensurate to their non-peer colleagues and respected for their experiential knowledge and contributions. The workplace is free of stigma and discrimination and built on equitable partnership. In this scenario, has co-production in BC been achieved? Unfortunately, the answer is not quite. Pay and respect are necessary

for the workplace but not sufficient conditions for systemic co-production. **Real transformation requires PWLLE to have influence at every level of the system, which includes the planning, development, implementation, and evaluation of services, policies, and programs** (45–47). One workplace is a start but cannot change the system any more than one peer worker can.

This statement is not intended to diminish the gains that workplaces have and can continue to make. Integration of peer workers at different work sites across the MHSU sector have positively influenced the system. Peer workers have helped to shift the power imbalance that exists between service users and service providers (48) and hold organizations accountable for their practices (35). Research demonstrates that simply having PWLLE on a team inspires more thoughtful use of language and leads to a more inclusive workplace and service. Mental health peer workers specifically have been found to promote a stronger commitment to recovery-oriented practice instead of the medical model within the organizations at which they work (35).

"Peers don't hold much power. You're at the bottom of the ladder, everybody else is above you. You work with people in different capacities, but you're always very much aware that you are low down."

– Peer participant

These benefits are indicators of progress towards co-production, but they are largely attributable to peers who deliver services and likely have limited opportunities to influence other levels of the MHSU system. Instances where peer workers are given representative roles to offer periodic input (49), such as contributions to meetings or advice on policymaking (14), are oftentimes tokenistic. In one-time engagements, or when organizations wait to invite peers until after decisions are already made, PWLLE are included but do not actually share power or participate in decision-making (50). A true sharing of power cannot happen until peers contribute to the decision-making processes that shape the services, policies, and programs that most impact their lives.

Some peer workers, however, contend that the growth of the peer workforce within the mainstream MHSU system risks co-opting service user activism. Peers who are employed by the very organizations and government agencies they are trying to change may feel pressured to accept, rather than critique, their employers' practices due to fears of losing their jobs (51) or a desire to retain their status or position. To reduce such pressures to conform, peer positions have to be intentionally embedded within the system to challenge the status quo and maintain their influence.

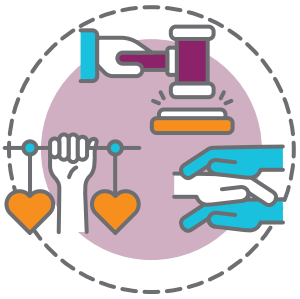
The core values of co-production are critical to achieve such systems transformation.

The most foundational core value is **collaboration and equal participation**, where peers and their non-peer colleagues share power through non-hierarchical, reciprocal relationships (1, 48, 51). This concept aligns with the principle of "nothing about us without us" that originated from and is resonated with disability rights, Indigenous, and drug user communities (13, 22).

The second core value is **building relationships and promoting social inclusion**, which entails that peers and their non-peer colleagues, alongside service users, experience a sense of belonging and no longer feel alienated from or discriminated against by the systems that are intended to support them (22, 48, 49, 52).

The third core value is the practice of **valuing individual contributions** by recognizing and appreciating different types of expertise, knowledge, strengths, and abilities (1, 48, 52, 53).

The fourth core value is **strengthening and bridging capacity** by providing opportunities for personal development (1, 49, 54), empowering peers to be involved in decision making (52, 54, 55), and creating networks for peers to share knowledge and support each other in navigating the formalized work environment (1, 48).



The fifth core value and most integral to producing positive change is **addressing inequality** by advocating for and promoting social justice and human rights (49, 52, 56) and striving to reduce health and social inequities (54, 56).

The underlying principles of a MHSU system realized through co-production are **harm reduction** (52, 54) and holistic '**recovery**' that replace a "cure" or elimination of symptoms with a focus on an individual's quality of life with regards to their relationships, community participation, and sense of wellbeing and empowerment (53). These principles are based on **self-determination**, a commitment on the part of services and their providers to trust that each person can make their own decisions and knows what path is most suitable to meet their needs (22, 48, 49).

The BC MHSU system and the services within it are far from co-production. Peers are inadequately paid, barred from participation at their work sites, forced to tolerate prejudicial beliefs about their lives and abilities, and stuck within service provision roles that marginalize their voices and viewpoints. Progress can be made one workplace at a time, but systemic change that embeds the values of co-production and realizes the principles of harm reduction and recovery for all persons accessing services is only possible with radical reform that centers the voices of PWLLE.

The Province of BC can achieve this by re-imagining the now defunct Office of the Mental Health Advocate and establishing a new body with statutory authority to receive and resolve complaints from service users, conduct systemic investigations, produce public reports, and provide recommendations for reform directly to the Legislative Assembly of BC. Instead of a single advocate, a committee of PWLLE should be appointed to embed experiential knowledge at every level and every corner of the system.

What We Learned from Peer Workers

Peer workers are often kept at the level of service provision. While supporting clients and their communities is intrinsically rewarding, the peer workers we spoke to were constantly confronted by services and systems that were inadequate and perpetuated harms, but felt powerless to change them. The knowledge they possessed about systems and the unmet needs of people who live with MHSU conditions were woefully underutilized and their voices silenced by workplace hierarchies and bureaucracies that either systematically devalued them or rendered them invisible. Most were stuck in low-level positions with no options available to grow on a career path. The few who had earned the esteem of their colleagues and communities and won a seat at provincial decision-making tables found their voices fell on deaf ears. The overwhelming sentiment was frustration fueled by a fierce commitment to change.

Lack of Career Mobility

The professional growth of peer workers is often limited in BC. Peers brought up that they were unable to move up in their roles, reporting that there was a glass ceiling for people in "peer" labeled roles or that a lack of formal education hindered their progress. The lived experience peers brought was considered by many to be a roadblock to their further success because of prejudicial beliefs about their capabilities, as well as employer preferences or union requirements for professional degrees. Some peers were able to move up into roles with more responsibilities, better compensation, and the ability to implement and plan programming, but this often required the support of non-peer staff and buy-in from the organization they worked for.

Tokenization

The impacts of tokenization were felt by many of the peer workers we spoke to. Some expressed a general sense of hopelessness from seeing the changes that needed to happen in the MHSU sector, yet feeling they had very little power to make a difference due to the limitations of their roles. Others felt their job did not matter since no one would listen to their perspective anyways. The emotional toll of this was significant and often led peers to feel resentment towards their workplace, contributing to low morale, poor job satisfaction, and high rates of turnover throughout the sector.

Resistance to Change

Peer workers who do achieve the security and power necessary to suggest change were often met with systemic resistance. Several peer supervisors or managers gave examples of instances when they tried to make a positive change for their peer teams or programming but failed because they were either bullied, ignored, or met with attitudes of complacency within their organization. Other peer supervisors or managers reported that they felt the needs of their teams and their own needs were denied due to the lack of influence they had in the workplace. Some participants reported that the entrenched hierarchies and levels of bureaucracy above them kept them from making any meaningful change.

Some of the peers who showed continuous career growth and had opportunities to sit at ministerial tables and contribute to policymaking similarly felt stifled after seeing first-hand the

changes that needed to be made within the sector. Peers who held leadership positions at their organizations and had power over the development and delivery of programming similarly felt their ability to exert influence at their workplace was curtailed and at the whim of budgets, precarious funding, expendable peer positions, workplace politics, and potential vetoing by non-peer staff.

> **"It felt like we were inviting peers for their expertise, and then if they don't tell us what we want to hear, we're excluding them."**
>
> **– Peer participant**

Discussion

The full realization of co-production at a systems level necessitates better oversight, monitoring, and improvement mechanisms for existing MHSU services to identify where gaps, failures, and inefficiencies prevent the delivery of harm reduction and **recovery-oriented care**. At present, no governance body is assigned this function in BC. Persons can file a complaint about the care they received with their health authority's Patient Care Quality Office (that is not required to provide a remedy), or with the Human Rights Tribunal if the complaint is about discrimination they experienced based on a protected identity under the BC Human Rights Code. In instances where the complaint is not about care or discrimination but about the administration of government programs and services, they can file with the BC Ombudsperson who can help to find a solution or conduct an investigation if all other complaint mechanisms have been exhausted. The challenge is that this patchwork of options is often unknown or inaccessible to most persons accessing mental health or substance use services, and the remedies they provide rarely lead to substantive policy or program amendments.

Several other jurisdictions have created robust accountability and oversight mechanisms for mental health services. The Australian province of Victoria established a Mental Health Complaints Commissioner (MHCC) as part of their *Mental Health Act 2014* (59).[133] The independent body is responsible for safeguarding rights, resolving complaints, and recommending service improvements. A key driver for the establishment of the MHCC was the Victoria government's commitment to uphold their *Charter of Human Rights and Responsibilities Act 2006* and Australia's obligations under the *United Nations' Universal Declaration of Human Rights* and *Convention on the Rights of* ***Persons with Disabilities*** (60). These human rights instruments promote the engagement of PWLLE in decision-making about services, policies, and programs that affect them. (22, 23)

The MHCC accordingly initiated the development of their Office by leading an extensive consultation with "**consumers**, families and carers as well as service staff and other stakeholders" and learned that an "independent, accessible, supportive and timely" complaints process needed to both respond to the needs of people accessing services and ensure their complaints would be used to drive systems change (60). The Commissioner is given these functions per Section 228 of the *Mental Health Act 2014* to not only resolve complaints in a timely manner, but also help services improve policies and procedures; identify, analyze, and review quality, safety and other issues arising out of complaints; and issue recommendations for service improvements to a number of relevant government bodies (59).

133 In 2022, Victoria updated its *Mental Health Act 2014*, resulting in stronger provisions related to the MHCC. The updated *Act* will come into effect in September 2023.

In 2016, the MHCC established an Advisory Council to facilitate input from PWLLE to contribute to practice improvement, education and engagement, and co-produce resources. Membership includes PWLLE, family members, service providers, and persons from priority population groups. Their contributions led to the development of "Driven by lived experience—beginnings, present & future," a framework and strategy to fully embed co-production principles and practices in the office of the MHCC. Some successes of this work are designated lived experience roles, a core principle of "driven by lived experience," and action statements and evaluation to measure progress towards co-production. (60)

Another example is Ireland's Independent Mental Health Commission ('the Commission') that was established "to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services" and to appoint an inspector to visit and inspect mental health facilities at least once a year and report on the quality of care and treatment. In contrast to the Victorian MHCC, the implementation of this law has not embedded principles or practices of co-production. The Commission is composed of practicing barristers or solicitors, registered medical practitioners, registered nurses, social workers, psychologists, and representatives from voluntary bodies who promote the interests of persons with mental illness and the general public. The appointed inspector is a consultant psychiatrist (63). The legislative provisions, to a certain extent, limit the participation of PWLLE and prohibit their equal participation. Still, the existence of a statutory mechanism for oversight demonstrates a necessary first step.

The concept of a governance body to monitor the performance of the mental health system is not new to BC. In 1998, the province's first Mental Health Advocate was appointed to perform this function and make recommendations about services and programs for people living with mental illness. Dr. Nancy Hall held this position for four years from 1998–2001 and was responsible for "reviewing quality of care issues, advising the Ministry of Health on the adequacy of mental health service, liaising with other local, regional, provincial and advocacy services, and helping to connect people with individual advocacy networks" (64). Her position was eliminated when the government changed in 2001 and was never re-established.

The reason the Office of the Mental Health Advocate was so easily eliminated was the lack of statutory authority. No legislative provision was created for the Office's existence or function and the Office reported to the government ministry (Ministry of Health) that it was meant to monitor and for which it provided recommendations. A new BC Office of the Mental Health Advocate ("the Office") should require statutory authority to, not only safeguard its existence from changing political tides, but also to clearly define its purpose, powers and membership, enshrine the principles of co-production, and establish its independence from government. Similar to the BCOHRC, the Office should report directly to the Legislative Assembly and possess powers to address not only individual, but also systemic harms (65). These legislative provisions are necessary to ensure accountability between the newly established Office and the provincial government, regardless of the political party in power.

Instead of one person empowered to oversee the MHSU system, a committee of persons with a range of diverse experiences should be appointed to lead the Office, with significant majority of persons who live with a mental health and/or substance use-related condition and have direct experience of accessing BC public services. The appointment process must carefully consider the

overrepresentation of Indigenous persons who experience mental illness and use drugs due to the ongoing harms of colonialism. It should also comply with DRIPA and uphold UNDRIP, and ensure Indigenous representation is equitable.

The primary function of the new Office should be to receive and resolve complaints. The Victorian model of the MHCC provides an illustrative example. The MHCC strives to acknowledge the experience, take action to resolve the complaint, and work with the offending service to offer an apology for the harm they have caused. (66) The four steps ensure that a complaint is not only heard and validated, but also contributes to service improvement to prevent harms from reoccurring and being experienced by multiple service users. The Office should follow this example and also add one extra dimension: advocacy. Once a complaint is made, the complainant would be assigned a Peer Advocate who would not only reactively address the harms they experienced and walk alongside them, but also proactively connect them to the right supports and services to maintain continuity of care. The presence of PWLLE at the committee and complaints levels further embeds their experiential knowledge, rebuilds trust with complainants to ensure they are not hesitant to access services when needed due to prior negative interactions, and contributes to the broader aim of reorienting the system around the principle of self-determination.

The secondary, but no less important, function of the Office would be systemic investigations. Since numerous complaints of a similar nature suggest structural harms, rather than interpersonal harms perpetuated by a single service provider, the Office requires this power to fulfill its function and begin to reform services to better deliver harm reduction and recovery-oriented care. Similar to Victoria's MHCC and the BCOHRC, the Office would be empowered to identify, analyze, and review quality, safety, and other issues arising out of complaints, publish reports, and issue recommendations to relevant public bodies. This legislative provision for the Office would additionally necessitate persons to whom the recommendations are made to notify the Office of steps taken to address the issues identified for the purposes of maintaining transparency and accountability.

The Office would be the necessary and final step towards co-production in BC. The impact would be enormous not only for peer employment or peer-employing workplaces, but also for the design, development, delivery, and evaluation of MHSU services across BC. PWLLE would truly be at the center of the system and possess the influence to reduce stigma and discrimination, legitimize experiential knowledge, redistribute and balance power between service users and service providers, and contribute to the improvement of supports and services to adequately and compassionately meet the needs of people living with mental illness and using substances.

Recommendation

We recommend the **Government of British Columbia** consider establishing a new Independent Office of the Legislature called the BC Office of the Mental Health Advocate. The Office should be composed of a committee of members who possess lived and living experience of mental illness, substance use, and public service access. The Office's role will be to receive and resolve complaints from service users, conduct systemic investigations, produce public reports, and provide recommendations for reform directly to the Legislative Assembly of BC to support all Members of the Legislative Assembly to monitor and assess government programs, procedures, and performance.

CONCLUSION

Peer employment has become increasingly prevalent across BC's MHSU sector as more organizations recognize the importance of experiential knowledge for the design, development, delivery, and evaluation of MHSU services. While some progress has been made, peer workers still face many barriers to accessing equitable employment in BC, and the sector has a long way to go towards truly achieving co-production.

Our research demonstrates that many peer workers have difficulty obtaining financial stability due to low wages, a lack of access to benefits, and job insecurity. Their level of choice and control or self-determination over their employment conditions is hindered by the scarcity of positions (especially outside of urban centers), and the predominance of part-time or casual roles that focus on service delivery. Many organizations remain oriented towards the traditional medical model and have hierarchical structures that are misaligned and at odds with the values underpinning peer work. Stigma and discrimination are still prevalent within the sector and lead peers to experience poor integration within multi-disciplinary teams and inequitable access to workplace resources and opportunities for career growth. Such bias is evident in the lack of funding and support provided to peer-run organizations compared to health authorities and non-peer-run community-based organizations. The consequences are that decisions about services and systems are often made without adequate input from peer workers, their experiential knowledge is frequently devalued, and they are rarely appointed to leadership positions with significant influence.

This report's recommendations describe a clear way forward to address these barriers and improve employment conditions for peer workers and MHSU services for all British Columbians. The peers we interviewed identified a number of factors necessary for creating equitable, supportive workplaces, and thereby ensuring the system and all who use it benefit from peer expertise. Peers need access to stable jobs that are fairly compensated, offer benefits and accommodations, and provide opportunities for career growth. Workplaces should empower peers to show up as their authentic selves with the autonomy to apply their expertise to shape the programming they offer and the policies that impact them. This fundamental redistribution of power depends on the peer role being understood and valued by all staff and the employer taking active steps to eliminate stigma and discrimination. Change at the organizational level can then inform the Province of BC's steps towards systemic reform and the establishment of a new Independent Office of the Legislature, the BC Office of Mental Health Advocate. This last step is imperative to ensure experiential knowledge is embedded at every level of the system.

Employers in the MHSU sector should no longer consider peer positions as optional, nor should they continue to perpetuate exploitation and harm peer workers. **The sector needs to adopt the mentality of "nothing about us without us" by ensuring peers can meaningfully participate and partner with their non-peer colleagues.** Co-production is how we will truly transform BC's MHSU system to one that upholds principles of harm reduction, holistic recovery and practices of self-determination for peer workers and service users alike.

Summary of Recommendations

We reccommend the **Ministry of Social Development and Poverty Reduction**, in partnership with the **Ministry of Health,** consider enhancing access to the peer support work income exemption for all peer workers in BC by:

a. Expanding eligibility for the income exemption from only peer support work to include all types of MHSU peer work where lived and living experience is a qualification for the position and necessary for the performance of job duties;

b. Developing a clear way of accessing and systemic way of processing the peer work income exemption, including eliminating the need for peer-employing organizations in the MHSU sector to be "designated agencies" through a health authority;

c. Developing educational resources for employers on how to facilitate the exemption for peer workers who are on income or disability assistance; and

d. Working with community partners to co-develop and distribute resource materials to peer workers to understand their eligibility and process for applying for the exemption.

We reccommend the **Ministry of Health**, in partnership with the **Ministry of Mental Health and Addictions**, consider continuing the work that began in *A Pathway to Hope* to increase opportunities for peers and improve peer work conditions within the MHSU sector by:

a. Recognizing peer support workers in the Health Human Resources (HHR) Strategy, which includes MHSU services as a priority area;

  i. For example, the Ministry of Health could include peer workers in the new employer-sponsored 'Earn and Learn' programs (Action #53 of the HHR Strategy), to reduce financial and other barriers to training and offer viable career growth opportunities for peers who want and are in a place to grow their careers;

b. Mandating that any paid peer positions in the MHSU sector funded by the Ministry of Health or the Ministry of Mental Health and Addictions, either directly or contracted through partners (e.g., health authority, community-based organization), are provided a liveable wage and benefits on par with similar non-peer positions, and;

c. Creating a funding stream exclusively for peer employment that is accessible to health authorities, non-profits, and peer-run organizations that are part of the MHSU sector. Employment conditions such as a liveable wage, benefits, and providing the income exemption should be mandatory eligibility criteria to apply for and receive the funding, which should be reviewed annually and be provided on a recurring, annual basis to organizations that continue to meet the conditions.

We reccommend the **Ministry of Mental Health and Addictions** consider dedicating funds for a peer-based or peer-employing organization to develop and deliver training to MHSU organizations on the role and value of peers in the workplace, the risks associated with re-traumatization in the workplace, and strategies to foster a trauma-informed and stigma-free workplace. The training could include components by and for Indigenous organizations that

address the ongoing harms of colonialism, culturally safe practices, Indigenous concepts of holistic wellness, and principles of self-determination.

We reccommend the **BC Office of the Human Rights Commissioner** consider expanding their current guidelines on employment equity to include examples of accessible workplace practices and intersectional accommodations that employers can enact and offer employees to increase inclusion of diverse persons who have mental health and/or substance use-related disabilities. The guidelines should specifically address peer workers, where the nature of their role may require them to disclose at least the existence of a health issue or disability or an aspect of their identity that is often subject to discrimination, and provide guidance to employers on the fulfillment of human rights obligations.

We reccommend the **Government of British Columbia** consider establishing a new Independent Office of the Legislature called the BC Office of the Mental Health Advocate. The Office should be composed of a committee of members who possess lived and living experience of mental illness, substance use, and public service access. The Office's role will be to receive and resolve complaints from service users, conduct systemic investigations, produce public reports, and provide recommendations for reform directly to the Legislative Assembly of BC to support all Members of the Legislative Assembly to monitor and assess government programs, procedures, and performance.

GLOSSARY

The following terms and abbreviations may have other definitions beyond this report. Our definitions are based on our research and reflect the manner in which these were commonly used by peer employers and workers. We have documented them here to assist the readers of this report.

ABSTINENCE	(def.) The process of abstaining—meaning not using or avoiding—addictive substances and/or behaviours.
BCOHRC	(abbr.) BC Office of the Human Rights Commission
CAPACITY BUILDING	(def.) The process of developing and strengthening the skills, instincts, abilities, and knowledge that peer workers need to perform their job duties. The benefit is assumed to be unidirectional, where peers need support to take on professionalized roles and are otherwise considered incapable.
CAPACITY BRIDGING	(def.) The relational process of peer and non-peer colleagues sharing their expertise and learning together to support one other to grow and develop their skills, instincts, abilities and knowledge. The benefit is assumed to be bidirectional since both forms of expertise are equally valid and valuable
CMHA BC	(abbr.) Canadian Mental Health Association, BC Division
CO-PRODUCTION	(def.) Equitable partnerships between peer and non-peer staff in the design, development, delivery, and evaluation of MHSU policies, programs, and systems.
EARNINGS EXEMPTION	(def.) Money earned by persons receiving income or disability assistance on top of their assistance payments (e.g., through employment) that does not change their monthly payment.
EFAP	(abbr.) Employee and Family Assistance Programming
ESA	(abbr.) Employment Standards Act
HOLISTIC	(def.) A wellness approach that aims to treat the whole person and considers their mental, physical, spiritual and social health, rather than focusing on the symptoms of their illness.
HONORARIUM	(def.) A one-time payment to compensate a peer for time spent contributing to the fulfillment of an organization's mandate.
LOW-BARRIER EMPLOYMENT	(def.) A paid work arrangement that does not require minimum qualifications and experience and does not necessitate a Criminal Record Check. Such arrangements are common among people who use drugs and/or are experiencing homelessness.

MENTAL HEALTH CONSUMER	(def.) A person who is obtaining treatment or support for a mental disorder—commonly used by health authorities to refer indiscriminately to peer workers and service users, and ameliorated by peer advocates as part of the consumer movement.
MENTAL HEALTH SECTOR	(def.) A network of services and supports dedicated to the treatment of mental illnesses and the improvement of mental health in people with mental disorders or problems
MHSU	(abbr.) Mental Health and Substance Use
MHSU SYSTEM	(def.) Laws, policies, oversight, services, supports and co-ordination necessary for the public provision of MHSU care to all British Columbians.
NON-BINARY	(def.) Gender identities that are not solely male or female
PEER	(def.) A member of a group of people who have shared experiences of mental illness and/or substance use.
PEER SUPPORT	(def.) A supportive relationship between people with common experiences of mental illness and/or substance use.
PEER SUPPORT WORKER	(def.) An employee who uses their lived experience of mental illness and/or substance use to perform their job duties to support a person experiencing mental health and/or substance use challenges.
PEER SUPPORT WORK INCOME EXEMPTION	(def.) An income exemption for peer support workers receiving income or disability assistance that allows them to retain their income earned through peer support work for a health authority or a designated agency of a health authority. Sometimes referred to as a 4C payment wherein 4C is the exemption code.
PEER WORKER	(def.) An employee who uses their lived and living experience of mental illness and/or substance use to perform their job duties within a social or health care setting.
PERSONS WITH DISABILITIES	(def.) A person who is eligible and designated by the Ministry of Social Development and Poverty Reduction to receive disability assistance and supplements through the BC Employment and Assistance Program.
PWLLE	(abbr.) People with lived and/or living experience/expertise (def.) Persons who self-identify as someone who has experience of mental illness and/or substance use.

SUBSTANCE USE SECTOR	(def.) A network of services and supports dedicated to harm reduction, treatment of addiction and the improved relationships with substance for people with substance use disorders or problems.
TOKENISM	(def.) The practice of recruiting and expecting one person or a small number of people to speak on behalf of people who have lived and living experience of mental illness and/or substance in order to give the appearance of inclusivity, diversity and/or equality. The practice is often unintentional and may happen when employers "fail to adjust culture, structures, or processes to address systemic barriers or bias towards defaulting to specific (often white, Eurocentric, etc.) identities and experiences as more important, credible, efficient or effective."(67)
RECOVERY	(def.) The self-defined process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.
RECOVERY-ORIENTED CARE	(def.) Self-selected, coordinated and person-centred supports and services for persons who are experiencing mental health and/or substance use challenges that helps them to achieve their goals for health and wellness.
VOLUNTEER	(def.) A peer who performs job duties either without compensation or for a small honorarium, wherein they are not an employee or in a paid position.

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