Lived Experience Leadership Roundtable

(Queensland)

Productivity Commission

Inquiry into Mental Health

Post Draft Submission

2020

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on behalf of the Lived Experience Leadership Roundtable

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We applaud and thank the Federal government for undertaking this review and the Productivity Commission's approach that includes consideration of social determinants and support from sectors outside health specific services.

The main aim of this submission is to advocate the role that an adequately valued and resourced Lived Experience (peer) workforce can play in progressing the Commission's reform agenda.

About the Lived Experience Leadership Roundtable

Brisbane based peer-operated service, Brook Recovery Empowerment Development Centre (Brook RED) and Brisbane North PHN jointly established the Lived Experience Leadership Roundtable (the Roundtable) as a forum for Lived Experience workers to problem solve the systemic challenges commonly experienced by the Lived Experience workforce across Queensland. Roundtable members include Lived Experience workers from across the state, working in diverse roles and in a variety of service settings (See Appendix 1).

The Roundtable undertook two state-wide Lived Experience workforce consultations in 2018. (Reports detailing the outcomes of these consultations are included in Appendix 2 and 3). Subsequently the Roundtable is now working towards establishing the Queensland Lived Experience Workforce Network (Q-LEWN) as a focused state-wide peak body led by, with and for the Lived Experience workforce.

Q-LEWN will be focused on ensuring volunteer and paid Lived Experience workers have access to support, professional development, and a collective systems advocacy voice. The Roundtable and the Q-LEWN initiative are unfunded, relying on the good will of the lead organisations and committed Lived Experience workers.

Draft Report Reform approach

The Draft Report identifies that the mental health service system is failing to improve the mental health of our population. Yet the Report largely reinforces the existing system by failing to

- Explore and identify the extent to which the dominance of biomedical etiology contributes to perpetuating the identified failings of a service system predominantly focused on acute clinical services
- Ensure meaningful Lived Experience involvement in co-design and co-production is appropriately resourced and embedded as central to the reform agenda
- Identify the need to ensure mental health services appropriately address the burden of complex trauma often at the core of the support needs of people using mental health services. This was articulately advocated in the Blue Knot submission 47

We argue that the final report be amended to embed trauma informed care across the service system and ensure that people with Lived Experience are involved in all aspects of planning and implementing action across all five reform areas. Hence, we emphasise and support the below positions previously presented to the Commission.

1. Irene Gallagher, Being CEO (Sydney public hearing) said that "If we are to truly change the way systems and services operate we need to shift our thinking from the current dominant biomedical discourse of pathologizing individuals as though something is wrong with them." We also strongly support her comment that "The fundamentals to any systemic change or the broader approach that I believe the Productivity Commission is looking to take and also what's needed for our community, is to ensure the coproduction, co-design and co-delivery is embedded in every aspect of the report."
2. National Mental Health Consumer and Carer Forum (submission provided prior to the release of the Draft Report) which advocates "Genuine commitment to co-production and/or co-design is properly resourced, embedded from the outset, effects real change; and can successfully measure meaningful outcomes for consumers and carers."
3. Blue Knot Foundation (submission 47 presented prior to the Draft Report) recommends "an 'empowering recovery from childhood trauma' model should be integrated into and across the mental health system. This will necessitate transformative change across and within services, systems and sectors to which consumers, experiencing mental distress, with a lived experience of childhood trauma present."

Co-design and Co-Production

We argue that the outcomes and experiences of people accessing services are central to all that occurs in our mental health sector. Therefore, valuing and understanding the perspectives of Lived Experience empowers and provides hope for people currently accessing services as well as contributing to transformational systems change, particularly in the increased understanding and adoption of Recovery orientated practice and more person centred approaches.[1]

The voice and expertise of people with a Lived Experience in transformational systems change is enshrined in public policy and increasingly emphasised by successive national policies and plans. Recently, the *Royal Commission into Victoria's Mental Health System Interim Report*[2] underlined the significance of Lived Experience understanding in helping to shape the future of Australia's mental health system.

Lived experience work will be a central pillar of the future mental health system, with new roles spanning service design and delivery, service and system leadership, research and evaluation, and system accountability and oversight.

Royal Commission into Victoria's Mental Health System Interim Report

The degree of influence lived experience perspectives can have is largely dictated by the willingness of those in power to share power and provide opportunity for impactful engagement. We have reached a point at which the need for change is undeniable and the means for change clearly includes a strong emphasis on co-production and leadership from people with Lived Expertise. Ultimately, by working towards people with a Lived Experience sharing influence at all levels of decision making, with impactful roles at all levels of organisations and across all relevant mental health and mental health adjacent organisations, we can create a system that is truly reflective of (and responsive to) the needs of those accessing services.

Co-design and co-production processes that acknowledge and embrace the expertise of people with Lived Experience (as well as respect for the views of the collective Lived Experience movement) are central to implementing authentic Recovery oriented and

[1] Byrne, L., Roennfeldt, H., O'Shea, P., & Macdonald, F. (2018). Taking a gamble for high rewards? Management perspectives on the value of mental health peer workers. *International Journal of Environmental Research and Public Health, 15*(4), 746. doi:10.3390/ijerph15040746

[2] State of Victoria (2019) *Royal Commission into Victoria's Mental Health System, Interim Report* Retrieved from https://s3.ap-southeast-2.amazonaws.com/hdp.au.prod.app.vic-rcvmhs.files/7615/7949/7906/Interim_Report_FINAL.pdf

person-directed approaches. Co-production requires acknowledgement of the unequal power roles that exist between people with Lived Experience (using services and/or working in Lived Experience roles) and the existing medical, health and research communities. To enable meaningful co-production, power must be actively re-distributed and shared. This includes funding; support for participants; and ensuring planning timeframes are appropriate.

If the Productivity Commission authentically wants to enhance consumer and carer participation across the mental health system (as per Draft Recommendation 22.3), then the Draft Report should actively demonstrate valuing and prioritizing the involvement of people with Lived Experience in co-design and co-production across all recommendations. The inclusion of recommendation 22.3 and obscure references in recommendations (eg "governments and service providers will consult with all stakeholders") does not demonstrate a strong position. Similarly, it is insufficient to assume the term "collaborate" infers co-design or co-production. Recommending that the NMHC "monitor and report on total expenditure on systemic advocacy" is equally inadequate. Meaningful co-design and co-production require governments and service providers to commit resources and funding to meaningful involvement of people with Lived Experience in decision-making.

We advocate that the final report

1. **Emphasise the central role that Lived Experience workers play in reforming mental health services**
3. **Include a firm commitment by governments and service providers to**
   a. **Involve people who use services and Lived Experience workers in co-design and co-production.**
   b. **Appropriately fund co-design and co-production.**
2. **Amend recommendation 22.3 to specify that Australian, State, and Territory governments involve people who use services and Lived Experience workers in the co-design and co-production of government policies and programs that impact their lives.**

Trauma-informed care

Currently the conceptualisation of mental illness is predicated solely on the biomedical diagnostic model of disorder. This often pathologises and further isolates people from the communities, cultural contexts and social supports critical to their recovery. In this system the context of people's lives, what happened or is happening to them, is/are rarely considered. Already isolated people experiencing mental distress are often isolated further in systems of treatment, which exclude, stigmatise and label.

Blue Knot submission 47

In their submission to the Productivity Commission (prior to the release of the Draft Report) Blue Knot comprehensively cited current research to identify the significance of the mental health system's failure to appropriately identify, acknowledge or address the burden of complex trauma that is core to the needs of people accessing services. They also presented the *Power Threat Meaning Framework*[3] as an evidence-based approach for trauma-informed support and advocated embedding trauma-informed practice across the mental health systems, services and sectors.

We strongly support the Blue Knot submission and are deeply disappointed to note the failing of the Commission's Draft Report to address the issues raised by Blue Knot or to include recommendations for imbedding trauma informed care across the service system as a fundamental reform recommendation for improving people's mental health outcomes and their experience of using services.

We advocate that the final report strongly recommend imbedding trauma informed care as a foundational approach across the mental health service system.

[3] Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society. Available on https://www.bps.org.uk/news-and-policy/introducing-power-threat-meaning-framework

About the Lived Experience workforce

"The mental health peer workforce is one of the fastest growing workforces in Australia, and supporting its growth and recognition as an emerging profession is crucial in helping people live contributing lives, and in building a stronger and more resilient mental health system."[1]

Jackie Crowe, Former National Mental Health Commissioner, 2014

For approximately a decade, government mandated standards, frameworks and policies have advocated mental health services incorporate diverse Lived Experience roles in mental health service delivery. For almost as long, Lived Experience workers, advocates, researchers and governments have acknowledged and debated the need for systemic Lived Experience workforce development and career pathways linked to nationally recognized vocational qualifications and standards.[4] [5] [6] [7] The recommendations included in the 2010 MHCCF consumer and carer identified workforce position statement[8] and the 2014 *Mental Health Workforce Australia Peer Workforce Study*[9] remain equally valid and (despite some progress) largely unaddressed in 2020. Significant recent development in acknowledging and formalising the paid contribution of people with a Lived Experience has occurred in Queensland, including the 2019 release of the *Queensland Framework for the development of the Mental Health Lived Experience Workforce*[10] and the *Queensland Health Mental Health Framework Peer Workforce Support & Development 2019*'[11]. The pending release of the National Peer Workforce Development Guidelines, a directive of the Fifth National Mental Health and Suicide Prevention Plan, will further promote the credibility and ongoing development of Lived Experience collaboration and contribution nationally.

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[4] Council of Australian Governments (COAG). (2012). The Roadmap for national mental health reform 2012 – 2022.

[5] Mental Health Workforce Advisory Committee (MHWAC). (2011.) *National Mental Health Workforce Strategy*. Victorian Government Department of Health. Melbourne. Retrieved from http://www.health.gov.au/internet/mhsc/publishing.nsf/Content/7AB7430A612FAB6FCA257A5D001B9942/$File/strat.pdf,

[6] Byrne, L. (2013). *A Grounded Theory Study of the Collaboration of Lived Experience Mental Health Practitioners within the Wider Workforce*. PHD Thesis, Central Queensland University, Rockhampton.

[7] Commonwealth Department of Health and Aging (CDHA). (2013). *A national framework for recovery-oriented mental health services. Retrieved* from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovpol

[8] National Mental Health Consumer and Carer Forum (2010) *The mental health consumer and carer identified workforce – a strategic approach to recovery*, NMHCCF, Canberra. Retrieved from https://nmhccf.org.au/sites/default/files/docs/mhca_carewf_layout_16-9_0.pdf

[9] Health Workforce Australia (HWA). (2014). *Mental Health Peer Workforce Study* Health Workforce Australia, Adelaide.

[10] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L. *Queensland Framework for the Development of the Mental Health Lived Experience Workforce. 2019,* Queensland Government: Brisbane

[11] Queensland Health (2019) *Queensland Health Mental Health Framework Peer Workforce Support & Development 2019* Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0039/929667/peer-workforce-support-framework.pdf

We welcome the inclusion of reforms to strengthen the Lived Experience workforce in the Draft Report. However, it is our opinion that the Draft Report fails to

- Sufficiently value and articulate the central role the Lived Experience workforce should play in progressing the Commission's broader proposed reform agenda
- Articulate the diverse roles the Lived Experience workforce plays in the mental health system
- Emphasize the imperative that the Lived Experience workforce lead and drive all initiatives focused on the development of our emerging discipline and rapidly expanding workforce

The *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*[12] argues that Lived Experience practice is about how experiences are understood and applied to benefit others. It articulates that Lived Experience practice contextualises experiences of challenge, service use and Recovery in relation to the wider Lived Experience movement and universal issues of marginalization and loss of identity/citizenship.

The Queensland Framework defines the Lived Experience workforce as people employed specifically to

- Use their personal understanding of life-changing mental health challenges, service use and periods of healing/ personal recovery, to assist others
- Use their life-changing experience of supporting someone through mental health challenges, service use and periods of healing/personal recovery, to assist others.

The Draft Report refers almost exclusively to the role that Lived Experience workers play in offering peer support to people accessing services. This fails to recognise that in addition to consumer and carer peer support, the Lived Experience workforce includes people with diverse skills and qualifications who work in designated Lived Experience roles in executive governance; board and committee representation; education; training; research; consultancy; policy design; and systemic advocacy across a variety of service settings including health and community based services; commissioning agencies; academia; industry; and private practice.

Recognising the diverse roles and skills across the Lived Experience workforce is significant because doing so enables the Commission to more accurately identify how Lived Experience researchers, educators, executives, advocates and peer support workers can contribute across the spectrum of reform recommendations.

[12] Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L. *Queensland Framework for the Development of the Mental Health Lived Experience Workforce. 2019,* Queensland Government: Brisbane

The Queensland Framework also identifies and acknowledges diverse specialisations within the Lived Experience workforce that are recommended in supporting people from diverse backgrounds and experiences. Specialisations listed include

- Aboriginal and Torres Strait Islander peoples
- People from culturally and linguistically diverse backgrounds
- People from the Deaf community
- People identifying as LGBTQIA+
- People with a history of trauma and/or family violence
- People with experiences of perinatal mental health
- People with experiences of eating disorders
- People with experiences of suicide
- People with experiences of involuntary treatment, incarceration and/or homelessness
- People with experiences of problematic alcohol and other drug use or dependence
- People identifying as neurodivergent
- People with disability
- Older people
- Youth
- Veterans

We advocate the final report

1. Emphasise the central role that Lived Experience workers play in reforming mental health services

2. Adopt the definitions of the Lived Experience workforce used by the Queensland Framework.

Draft Recommendation 11.4 Strengthening the Peer Workforce

Short Term Recommendations

National Guidelines

> The National Mental Health Commission should, when submitting its finalised national guidelines on peer workers to governments for approval in mid-2020, recommend how the guidelines should be supported by work standards for particular areas of practice.
>
> Draft Recommendation 11.4

We draw to the Commission's attention the process that the Queensland Mental Health Commission (QMHC) followed in developing the *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*. Lived Experience workforce leaders worked closely with QMHC to oversee the development of the Queensland Framework which was undertaken by a Lived Experience team of researchers (headed by Dr Louise Byrne). The process of drafting the guidelines included broad consultation with the Lived Experience workforce state-wide (See Appendix 4 for more detail). We consider this a good practice example of how government agencies can support the Lived Experience workforce to lead and drive its own development. We believe it is significant that Lived Experience researcher Dr Louise Byrne has been appointed to lead the development of the National Peer Workforce Development Guidelines for NMHC, a directive of the 5th National Mental Health and Suicide Prevention Plan. The Roundtable has committed to embed the Queensland Framework as a core focus in guiding the direction of Queensland Lived Experience Workforce Network (Q-LEWN) as it becomes established as a state peak body driven by and for the Lived Experience workforce. There is an expectation that QMHC and Q-LEWN will continue to collaborate on how to promote the effective implementation of the Queensland Framework.

From this context, we agree with the Productivity Commission's suggestion that the development of state and national Lived Experience workforce guidelines will be significant in stimulating reform to address the barriers and challenges currently faced by this workforce. However, there have been criticisms of previous national and state mental health plans for a perceived lack of ensuring recommended actions are implemented.

In 2010 the National Mental Health Consumer and Carer Forum (MHCCF) advocated that "As part of the national mental health strategy, governments, mental health policy makers and mental health consumer and carer identified workers urgently need to focus on the future development of the mental health consumer and carer identified workforce to ensure its sustainability." They also called on State, Territory and National governments to develop "a national mental health Consumer and Carer identified Workforce Development strategy".[13]

We advocate that the final report include recommendations to ensure that

1. **The updated National Mental Health Workforce Strategy integrates and emphasises recommendations from the pending National Peer Workforce Development Guidelines. This should include advice on how governments should financially contribute. Examples include providing seed funding to establish professional peaks**

2. **The updated National Mental Health Workforce Strategy includes an actionable list of priority areas, bodies responsible, and expected timeline**

3. **An independent body audit the progress of implementing the proposed actions for the sustainable and supported development of the Lived Experience workforce nationally**

[13] National Mental Health Consumer & Carer Forum (NMHCCF). (2010) *Supporting and developing the mental health consumer and carer identified workforce – a strategic approach to recovery: A position statement*. NMHCCF, Canberra. Retrieved from https://nmhccf.org.au/publication/supporting-and-developing-mental-health-consumer-and-carer-identified-workforce

Occupational Representation

The National Mental Health Commission should, by the end of 2019, submit a recommendation to the Australian Government on how to establish a professional organisation to represent peer workers. This should include advice on how governments should, if at all, make a financial contribution, such as by providing seed funding to establish the professional organisations.

Draft Recommendation 11.4

As the fastest growing health workforce in Australia, the Lived Experience workforce is no longer an 'optional' or marginal concern. Lived Experience work is rapidly developing in both state government and non-government settings. However, as noted, there has been no census of workers; no consistency in remuneration, education or professional development; and no professional national advocacy body or union to guide the development of the workforce. Consequently, the development of roles has been ad hoc and (at times) seen the inappropriate development of roles with poor support and risk to workers. Funding for a national peak, led by reputable Lived Experience leaders and informed by the existing state bodies cannot be optional, when so many people's livelihoods and the ongoing development of the workforce is at stake. Therefore, we endorse the need to establish a national peak body for the Lived Experience workforce. We agree that establishing such a body will require support (including funding) and consultation with National, State and Territory governments. We also appreciate the sense of urgency to ensure that action is implemented within the next two years. However, we strongly support the position put forward by Shauna Gaebler (Consumers of Mental Health Western Australia) during the Commission's public hearing in Perth. Ms Gaebler articulated that

> "The establishment of a national peer support professional organisation must be led by and for peer workers, rather than from an external non-peer entity, including the National Mental Health Commission, government, and/or clinicians."

Draft Recommendation 11.4 does not clearly identify the imperative to resource and strengthen the leadership capacity of the Lived Experience workforce to drive the representation and development of our workforce. It is crucial that the promotion of Lived Experience leadership roles in research, education, training and service delivery take into account the differences between *having* a Lived Experience and *being* a Lived Experience worker. There is risk of people being appointed to senior roles who have a personal lived experience, but no prior experience working in Lived Experience

positions and no (or limited) understanding of the wider discipline. This is a risk which especially concerns us if senior government positions are created to guide Lived Experience workforce development. Networks with the wider Lived Experience movement, understanding and application of the broader thinking in the movement are essential to the authenticity and efficacy of Lived Experience roles.

The wording of Draft Recommendation 11.4 infers there is scope for the NMHC to provide recommendation to the Australian Government (regarding how to facilitate a national peer workforce organisation) based solely on the feasibility study they funded the Private Mental Health Consumer Carer Network to produce. There are state level consumer peak bodies established across Australia, most of which play a role in supporting and representing the views of the Lived Experience workforce. As identified earlier, the Queensland Lived Experience workforce is in the process of establishing a state level peak body specifically to represent their interests. These bodies must have input into any recommendations made by NMHC to the Australian Government.

The Draft Report (p7) asserts that the reforms "provide incentives for key players to work together *without relying simply on the goodwill of committed staff*" (Italics added for emphasis). This is directly contradicted by the wording of Recommendation 11.4 which infers scope for NMHC to advise the Australian Government it is not obligated to financially resource the establishment of a Lived Experience workforce peak body.

As identified earlier, the Lived Experience Leadership Roundtable (and its work to progress the establishment of a state level Lived Experience workforce peak body) is currently unfunded. The Roundtable was first established in 2017. The lack of funding has hampered the Roundtable's capacity to progress its goal to establish a state peak body driven by and for the Lived Experience workforce. This is despite the goodwill of the leading organisations; commitment by Roundtable members, mandate from the workforce and the sense of urgency that we all feel in relation to the importance of establishing a state peak. Lived Experience workforce development has been acknowledged as an urgent issue since 2010, but progress has been slow and patchy, largely due to a lack of committed funding. Therefore, funding commitment by National, State and Territory governments is not optional – it is essential to ensure the implementation of recommendations.

We advocate the final report amend Recommendation 11.4 to include

1. A prelude statement to identify that is essential that all initiatives intended to strengthen the Lived Experience workforce must be led by Lived Experience workers with the support of National, State and Territory governments and service providers.

2. A recommendation for ensuring the perspectives employed in senior Lived Experience positions are aligned with the emerging discipline and its accepted values and principles as detailed in the Queensland Framework and National Guidelines.

3. The requirement that any recommendations made by the NMHC must be generated through a co-production process involving the state-based consumer peaks and facilitated by Lived Experience leaders with experience of being employed in Lived Experience roles within the mental health sector.

4. The requirement that National, State and Territory governments commit funding to support the development of the Lived Experience workforce, including establishing state and national peak bodies led by and for Lived Experience workers.

Medium Term Recommendations

Lived Experience led education for all mental health professionals

> The Australian, State and Territory Governments should, in consultation with stakeholders, develop a program to educate health professionals about the role and value of peer workers in improving outcomes. The program will need leadership to improve workplace cultures.
>
> Draft Recommendation 11.4

The Draft Report proposes that addressing the undervaluing of the Lived Experience workforce will require educating health professionals and will be facilitated by the Draft Recommendation 20.1 – National Stigma Reduction Strategy. We agree that the undervaluing of the Lived Experience workforce is linked to the broader issue of prejudice and discrimination experienced commonly by people with mental health issues or diagnosed with mental illness. We also agree that educating mental health professionals is a vital component of systemically changing negative attitudes and improving the practices of mental health professionals. We were pleased to note Draft Recommendation 20.1 identifies that a national 'stigma' reduction strategy should "rely on the leadership and direction of people with Lived Experience" and should actively target prejudice and discrimination by health professionals.

However, the Draft Report fails to recognise the role of Lived Experience academics and educators or the vital role that their involvement in the design, delivery and evaluation of curriculum plays in contributing to the education for mental health professionals. We consider this is especially significant when considering reforms to undergraduate qualifications for mental health nurses, social workers, psychologists, psychiatrists and GP's. The involvement of Lived Experience educators is equally important to the ongoing professional development for all mental health professionals and allied health professionals.

From the mid 1990's government policies have mandated Australian mental health services provide Recovery focused care, demanding people who use services (as consumers or care-givers) are involved at all levels of decision-making (from individual treatment, through to service and policy development). Consequently, mental health practice is dependent on the capacity of health professionals to engage and work collaboratively with people who access services for treatment and support.[14] For this reason, Lived Experience involvement in the education of neophyte and post qualified

[14] Miller ME, Siggins I, Ferguson, M & Fowler G (2011) *National mental health workforce literature review*, Melbourne, Dept of Health.

mental health professionals has also been identified in Australian policy frameworks such as the *National Framework for Recovery-oriented Mental Health Services; National Safety and Quality Health Service Standards* and discipline specific standards such as the *National Framework for Postgraduate Studies in Mental Health Nursing* and *Accreditation Standards for Occupational Therapy Education Program*. Since 2002 industry standards in the UK have mandated Lived Experience involvement in the design, delivery and evaluation of qualifying and postgraduate social work education.[15]

Emerging literature suggests Lived Experience involvement (in curriculum development, delivery and evaluation) can facilitate transformative learning that promotes positive attitudinal change; improves understanding of patient experiences; and promotes self-reported changes in work practice and higher professional confidence.[16] [17] [18] Involving people with Lived Experience in educating mental health professionals can be tokenistic; and lacking robust research and evaluation.[19] [20] In 2015 over 70% of Australian universities included Lived Experience led lectures in education of mental health professionals. But, in the majority of cases this was limited to guest presentations or providing feedback. Processes have been described as typically ad hoc and lacking a framework for training and supporting Lived Experience educators to maximise efficacy.[21] A systematic framework is pivotal to ensuring Lived Experience participation is both purposeful and meaningful; agreed goals and benchmarks are articulated to ensure consistency and accountability; to address the training needs and supports of Lived Experience educators; and to promote relationships between academic institutes and community based health and Lived Experience networks. [22] [23] [24] As with previous recommendations, the distinction should be made between people

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[15] Wallcraft, J; Fleischmann, P; Schofield, P;. (2012) *The involvement of users and carers in social work education: a practice benchmarking study. Workforce Development: Report 54.* Social Care Institute for Excellence, London.

[16] Happell, B; Bennetts W; Tohotoa j: Wynaden D; and Platania-Phung C (2017) Promoting recovery-oreinted mental health nursing practice through consumer participation in mental health nursing education. *Journal of Mental Health*, UK DOI: 10.1080/09638237.2017.1294734

[17] Arblaster, K; Mackenzie, L: Willis, K.(2015) Service user involvement in health professional education: is it effective in promoting recovery-oriented practice?, *The Journal of Mental Health Training, Education and Practice*, Vol. 10 Issue: 5, pp.325-336, https://doi.org/10.1108/JMHTEP-04-2015-0016

[18] Obid op cit

[19] Happell, B (2014) *Consumer participation in education and training of mental health nurses. Issues paper* Queensland Mental Health Commission, Brisbane.

[20] O'Brien, N; Dadswell, A. (2017) *Developing and showcasing FHSCE Strategy for involving Experts by Experience in Teaching, Learning and Research.* Project Report. Anglia Ruskin University, Chelmsford. Available from http://arro.anglia.ac.uk/702559/

[21] Happell, B; Platania-Phung C; Byrne L; Wynaden D; Martin G; and Harris S (2015) Consumer participation in nurse education: A national survey of Australian universities. *International Journal of Mental Health Nursing* 24, 95-103 doi: 10.1111/inm.12111

[22] Robertson R & Nelson A (n.d) *Consumer involvement in education: A discussion paper for education and tertiary training providers.* Matua Raki South Wellington NZ Retrieved from https://www.matuaraki.org.nz/uploads/files/resource-assets/consumer-involvement-in-education-May-2012.pdf

[23] Happell, B. & Roper, C. (2009). Promoting genuine consumer participation in mental health education: A consumer academic role. *Nurse Education Today*, 29, 575–579.

[24] O'Brien, N; Dadswell, A. (2017) *op cit*

having a lived experience, and those primarily working from the lens of the collective Lived Experience movement.

We advocate the final report amend Recommendation 11.4 to

1. **Increase the priority (from medium to short term) of Draft Recommendation 20.1 which advocates stigma reduction programs be incorporated in the initial training and continuing professional development requirements of all mental health professionals.**

2. **Include a recommendation for systematically embedding Lived Experience led education for mental health professionals. This should include Lived Experience involvement in curriculum development, delivery and evaluation.**

3. **Include a recommendation to provide and promote Lived Experience designated research scholarships at research higher degree (RHD) and early career, mid career and professorial levels.**

Lived Experience practice qualifications and professional development

The Australian Government should, in consultation with State and Territory Governments and other stakeholders, commission a national review to develop a comprehensive system of qualifications and professional development for peer workers. This should consider how peer worker qualifications would be recognised as prior learning for health professional qualifications.

Draft Recommendation 11.4

We support Commission's position on the need to develop a specific Lived Experience graduate training program, including more on-the-job traineeships and recognition of prior learning. We also support the concept of a medium term recommendation proposing the Australian Government should commission a national review to develop a comprehensive system of qualifications and professional development for Lived Experience workers.

However, we argue that the wording of this recommendation (that the Australian Government does so "*in consultation* with State and Territory Governments and other stakeholders") fails to reinforce a position that the process should be led by Lived Experience workers.

We also ask the Commission to take a firm position in advocating that there *is* a role for governments and other services to provide scholarships to enable people with Lived Experience to participate in available training and to provide funding for Lived Experience academic positions to guide the development and delivery of that training.

We advocate the final report amend Recommendation 11.4 to

1. **Ensure that Lived Experience academics and Lived Experience workforce leaders are supported by relevant government agencies to drive a national review for developing a comprehensive system of qualifications and professional development for the Lived Experience workforce**

2. **Identify National, State and Territory governments and service providers have a responsibility to fund professional development for Lived Experience workers and provide scholarships to enable people with Lived Experience to participate in available training**

3. **Identify National, State and Territory governments fund Lived Experience academic positions to guide the development and delivery of education for Lived Experience workers**

Summary of key points

Reform Approach

The final report should

- Entrench trauma informed care as fundamental across the mental health service system
- Clearly identify and embed the essential role of involving people who use services and Lived Experience workers in co-design and co-production across all reform recommendations
- Identify that a firm commitment by governments and service providers is required to adequately fund and resource engagement processes to facilitate meaningful involvement of people with Lived Experience in co-design and co-production

Strengthening the Lived Experience workforce

The final report should

- Recognize the central role that the Lived Experience workforce plays in system reform for improving mental health outcomes and experiences of using services for people seeking support; the key role of Lived Experience workers in improving the implementation of Recovery-oriented and person-directed approaches in service delivery; and the diverse roles and skills that currently exist across the Lived Experience workforce
- Specify that the establishment of a national Lived Experience workforce professional organisation must be led by Lived Experience workers and supported by governments
- Ensure the perspectives employed in senior Lived Experience positions are aligned with the emerging discipline and its accepted values and principles as detailed in the *Queensland Framework* and pending National Guidelines
- Ensure that Lived Experience academics and Lived Experience workforce leaders are supported to drive the commissioning and undertaking of a national review to develop a comprehensive system of qualifications and professional development for peer workers
- Systemically embed Lived Experience led education for mental health professionals including Lived Experience involvement in curriculum design, delivery and evaluation of undergraduate and post-graduate qualifications and ongoing professional development
- Identify the responsibility of governments and services to provide scholarships to enable people with Lived Experience to access training (from Certificate IV through to post-graduate levels) and undertake research (from Research Higher Degree through to professorial levels)

Appendix 1: Lived Experience Leadership Roundtable members

Eschleigh Balzamo	Brisbane CEO Brook Recovery Empowerment Development Centre
Paula Arro	Brisbane Lived Experience Engagement Coordinator Brisbane North PHN
Viv Kissane	Brisbane CEO Peach Tree Perinatal Wellness
Lisa Jones	Brisbane Director of Recovery Metro North Mental Health (Qld Health)
Gabrielle Vilic	Brisbane Director for Social Inclusion and Recovery Metro South Addiction and Mental Health Services (Qld Health)
Karalee Busniak	Brisbane Senior Peer Facilitator Footprints
Donna Humphrey	Brisbane Peer Workforce Engagement and Development Coordinator Brook Recovery Empowerment Development Centre
Tanya Ketschmann	Brisbane Lived Experience educator and consultant
Michelle Edwards	Gold Coast Carer Consultant Mental Health Services Gold Coast (Qld Health)

Amanda Waegeli	Darling Downs Lived Experience educator Private Consultant
Michael Burge AOM	Darling Downs Consumer Consultant Adult Mental Health Services (Qld Health)
Liz Guaresi	South Burnett Peer Support Worker Lutheran Services, Kingaroy
Michael Burbank	Sunshine Coast Teacher (Cert IV Mental Health Peer Support Work) Queensland TAFE
Evan Foulton	Wide Bay Manager Flourish Peer Operated Service (Hervey Bay)
Dr Louise Byrne	Central Queensland Lived Experience Researcher/Fullbright Fellow RMIT School of Management
Tyneal Hodges	Lived Experience educator and consultant Cairns

Appendix 2: Q-LEWN 2018 Survey Report

QUEENSLAND
LIVED EXPERIENCE WORKFORCE NETWORK

2018 SURVEY

BROOK red recovery empowerment development PEER SUPPORT

phn BRISBANE NORTH
An Australian Government Initiative

Acknowledgements

This project was initiated and funded by Brook RED and Brisbane North PHN and supported by the Lived Experience Leadership Roundtable.

We acknowledge and pay respect to Aboriginal and Torres Strait Islander peoples as the traditional custodians of the land and waters on which we live, work and play.

We would also like to acknowledge and thank the members of the Lived Experience Leadership Roundtable for their ongoing support in working towards ensuring that Lived Experience workers drive workforce development for the Lived Experience sector and for their contributions in designing and distributing this survey.

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Executive Summary

Background

In October 2017, Brook RED and Brisbane North PHN invited Lived Experience leaders from across Queensland to a roundtable discussion about Lived Experience workforce development needs and how to progress recommendations from the *Identifying barriers to change: The lived experience worker as a valued member of the mental health team report* funded by the Queensland Mental Health Commission (QMHC). This group subsequently formalised as the Lived Experience Leadership Roundtable and determined that a Lived Experience Workforce peak body (*owned by and driven by Lived Experience workers) was needed.*

At the request of the Roundtable, Brook RED and Brisbane North PHN held the *Building Foundations Forum* in May 2018 to engage the Lived Experience workforce more broadly. The *Forum* was attended by over 70 Lived Experience workers from across Queensland and confirmed the need for sector leadership; support; professional development; and collective systems advocacy to address Lived Experience workforce issues. Forum participants voiced strong support for creating a focused state-wide peak body led by, with and for the Lived Experience workforce.

Subsequently, the Roundtable resolved to undertake further consultation with the sector, to inform the focus and direction for establishing the Queensland Lived Experience Workforce Network as an independent peak body. This was undertaken through circulating the *Queensland Lived Experience Workforce Network 2018 Survey* and holding a strategic planning forum in November 2018. Outcomes of the strategic planning forum are documented separately.

Survey Results

Survey Monkey was used to create an online, anonymous survey, which was distributed electronically (to Lived Experience workers across Queensland) by members of the Roundtable through formal and informal networks. 151 responses were received between the 1st and the 23rd November, 2018.

Focus and direction for proposed peak body

Respondents confirmed that Lived Experience workers want to decide and drive policy about workforce development for their sector.

Respondents identified that a peak body led by, with and for Lived Experience workers needs to

- Advocate for people working in both consumer and carer focused roles
- Be inclusive of rural and remote regions
- Be managed by a board of Lived Experience workers
- Be transparent and accountable to its members
- Enhance the interconnectedness of Lived Experience workers

Respondents also commented a peak body needs to create and promote a culture that

- Ensures acceptance of and respect for diverse views
- Promotes equality and equity
- Promotes inclusive language and recovery focused practices

The top five priority areas for a Lived Experience Peak body were identified by respondents as

1. Education and training
2. Supervision and mentoring
3. Treatment in the workplace
4. Systemic advocacy and lobbying
5. Workforce advocacy

Additional comments identifying systemic issues impacting Lived Experience workers were themed as

- Workforce recognition and validation
- Professional development
- Working conditions
- Integrating the Lived Experience workforce
- Growing the Lived Experience workforce

Respondent Demographics

Age and Gender

72% of respondents identified as female, 26% male, and 2% non-binary. Three quarters of all respondents identified as being between 25 and 54 years old. 19% (almost one in five) were aged 55 or more and only 5% (or one in twenty) were 24 years old or younger.

Location

150 respondents identified working in 13 Hospital and Health Services (HHS) districts. No responses were received from Lived Experience workers in the North West or Central West HHS districts. Eight out of ten respondents worked across the South East region (ie Wide Bay; Sunshine Coast; Metro North; West Moreton; Metro South and Gold Coast). 7% of respondents identified working across 2 or more HHS districts.

Roles

46% of respondents worked in consumer roles; 41% in combined consumer/carer roles and 13% in carer only roles. 41% of respondents worked for not for profit services, in addition to 21% working in peer-operated services (which are predominantly not for profit services); 26% worked for public health services and 7% worked in private practice (including as self employed consultants). The remaining respondents identified as working in academia (2%); or were students (2%) or volunteers (2%). Almost one third of respondents identified working full time and half of respondents had been in the their current role for more than two years.

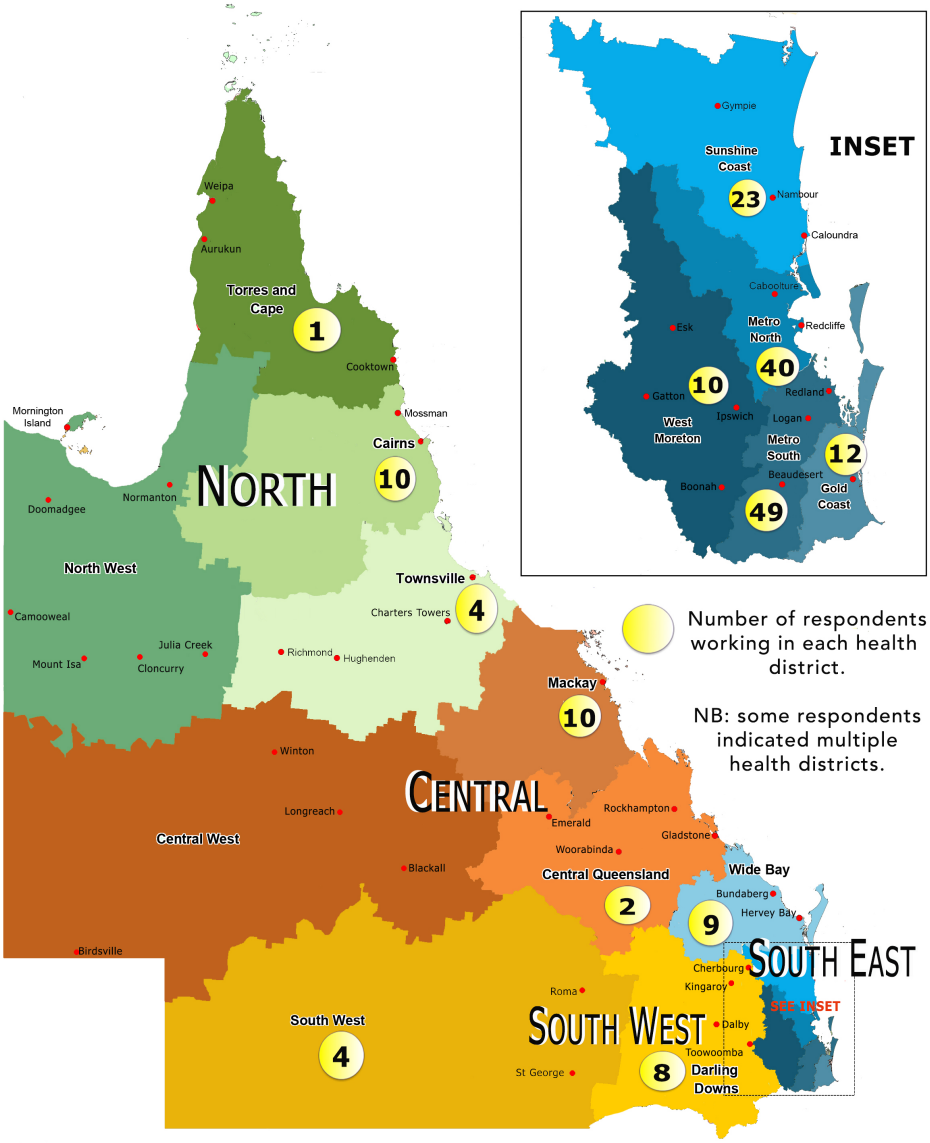
Professional Development and Networking

Almost one third of respondents received no professional development; just under half of respondents received professional development provided by their employers; and 14% received professional development by external providers. Almost half of respondents networked in their local area; one quarter networked at a state level; almost one in five networked at a national level; and almost one in ten respondents networked at an international level. More than half of respondents networked at multiple levels. More than half of respondents networked via phone, email or online. Less than one-third of participants networked through face-to-face meetings.

Respondent Demographics

Location

In response to the question "what regional areas do you work in?" 11 respondents (7%) identified working across 2 or more Hospital and Health Services (HHS). One respondent identified working across thirteen out of fifteen HHS districts (excluding Central West and North West). One respondent identified working across six HHS districts (Metro North; Metro South; Darling Downs; West Moreton; Sunshine Coast and Wide Bay). 4 respondents (2.6%) identified working across Metro North and Metro South; 4 respondents (2.6%) worked across Metro South and Gold Coast; 1 respondent worked across Metro South and South West; and 1 respondent worked across Metro North and Sunshine Coast. 1 survey respondent didn't identify any region.

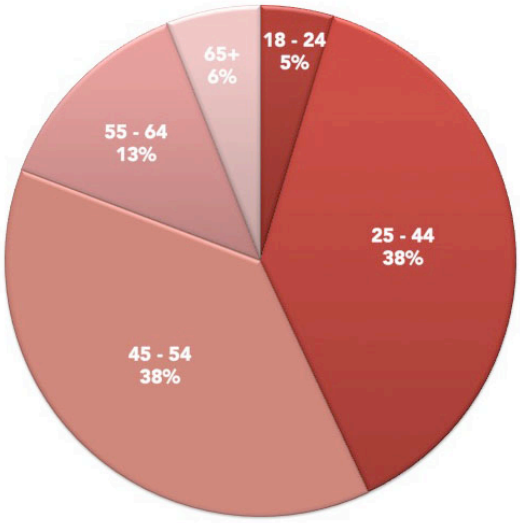


Adapted from *Hospital and Health Services, Queensland Health by Recognised Public Hospitals and Primay Health Centres* (2017)
Statistical Reporting and Coordination, Statitical Services Branch

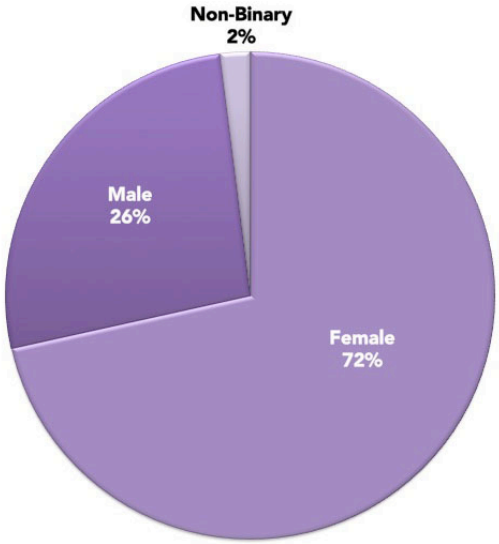
Age and Gender

151 survey respondents answered questions identifying age and gender.

Age



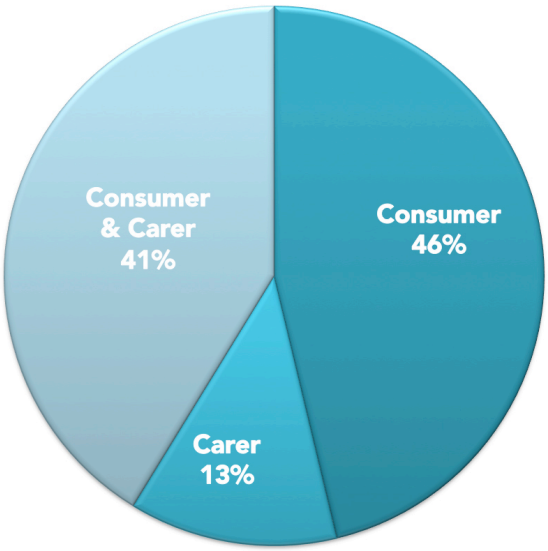
Gender



Professional Characteristics

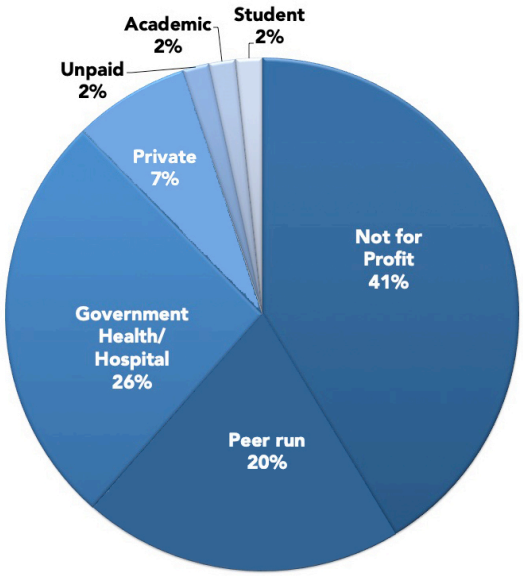
Current Lived Experience Role

149 respondents answered the question "*How do you identify your Lived Experience role?*"



Employing Organisations by Type

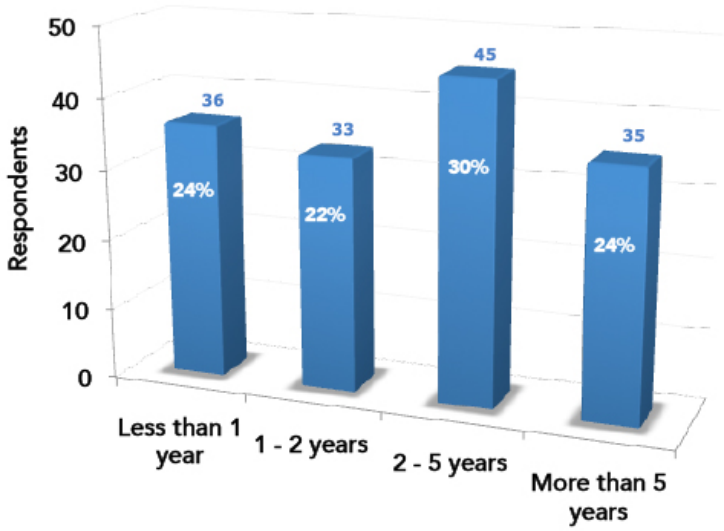
150 respondents answered the question "*What type of organisation are you working for?*" Listed options included non-for profit; peer run; government health/hospital; or other with an option to provide details. Respondents could select multiple options. 13% of respondents identified two or more organisational types. Each descriptor selected by a respondent was counted separately.



However, it is noted that the survey design was such that it is unclear if selecting multiple options was intended to identify working simultaneously for two or more organisations as opposed to using multiple descriptors for a single organisation. For example, indicating both "non for profit" and "peer run" could be referring to two separate organisations. But given that peer run services in Queensland are predominantly non-profit organisations, it could also be intended to describe different aspects of a single organisation.

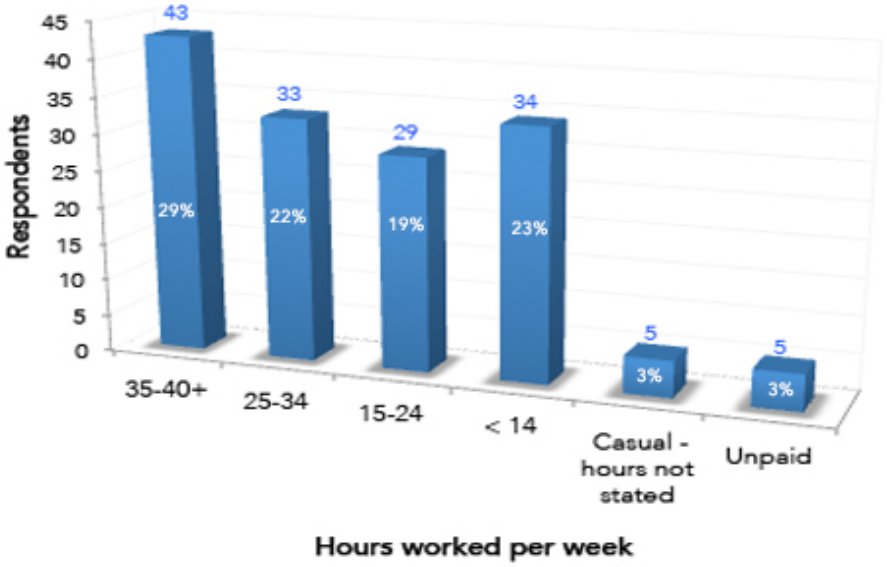
Length of Service in Role

149 respondents answered the question "*How long have you worked in this role?*" This does not capture the length of time someone has been employed (potentially across multiple roles) as a member of the Lived Experience workforce. So someone could have been in employed their current role for less than one year, but have fifteen years experience working as a Lived Experience worker.



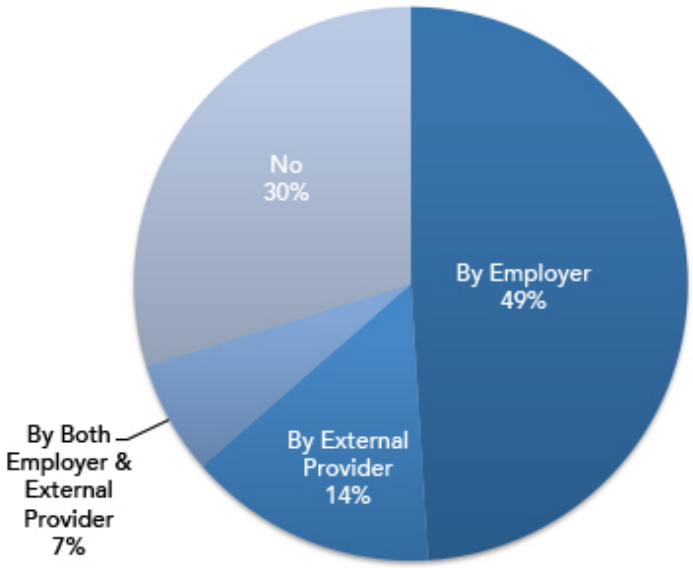
Hours Worked per Week

150 respondents answered the questions "*How many hours a week do you work in this role?*"



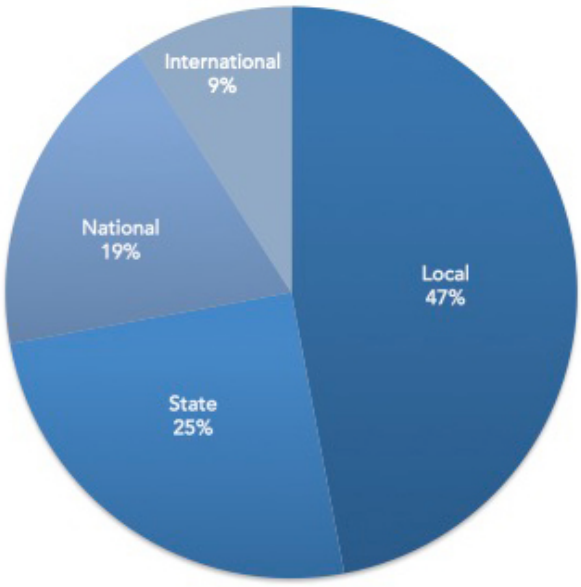
Professional Development and Training

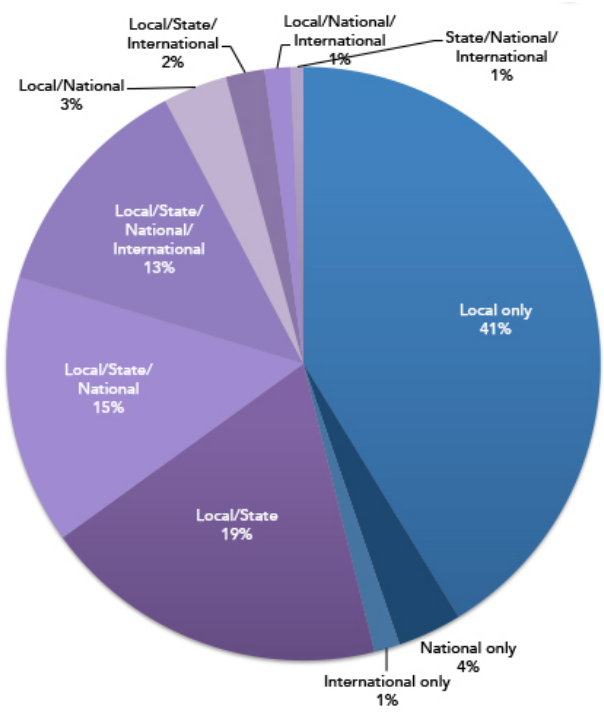
151 respondents selected from listed options "*Yes – My organisations provides it*'; '*Yes, by an external provider*"; or "*No*" to answer the question "*Do you receive ongoing professional development/training specific to your Lived Experience skillset*?" Respondents could choose multiple options.



Networking

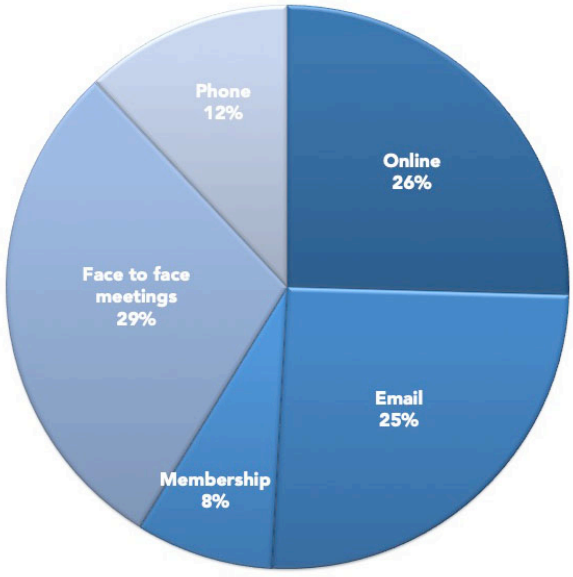
146 respondents answered the question "What existing networks or supports do you engage with?" 47% of respondents selected only one item from the listed options (local; state; national or international); 21% selected two options; 19% selected three options; and 13% selected all options.





32 respondents answered the component of the question that asked "*If possible, please name the networks.*" The survey didn't provide a definition of "networks". Consequently the answers included organisations, programs and networks.

Method of Engaging



145 respondents selected from listed options (email; online; membership; face to face; and phone) to answer the question "*How do you normally connect to Lived Experience networks*?"

Networks

Local

- Gold Coast Peer Workers Network
- Peer Skills Community of Practice (convened by Brook RED)
- Peer Participation in Mental Health Services (PPIMS) Network (Brisbane)
- Mountains of Hope Peer Support Network (Toowoomba)
- Wide Bay Peer Support Workers Network
- Peer Alliance Sunshine Coast (convened by Community Focus)
- Lived Experience Academics Program (LEAP) (convened by Sunshine Coast Mind & Neuroscience Thompson Institute)
- Logan Beaudesert Mental Health Professionals Network
- Nanango women's group

State

- Queensland Injectors Voice for Advocacy and Action
- Psych Action/Activism & Training (PAT) group convened by Cath Roper in Victoria
- Mental Health Lived Experience Engagement Network (MHLEAN) (PHN)
- Peer Supported Open Dialogue Community of Practice
- Lived Experience Leaders' Roundtable (Q-LEWN working group)
- Hearing Voices Queensland

National

- Australian Hearing Voices Network
- Peer Workers Network (Facebook)
- Clubhouse Australia
- Consumers of Mental Health Western Australia
- Victorian Mental Illness Awareness Council
- Recovery Rocks Community (Western Australia)
- NEAMI National networks
- Australian branch, International Society for *Psychological* and Social Approaches to Psychosis
- Mental Health Coalition of South Australia
- GROW
- Arafmi
- Narcotics Anonymous
- The Australian Injecting and Illicit Drug Users League
- Perinatal Anxiety & Depression Australia

International

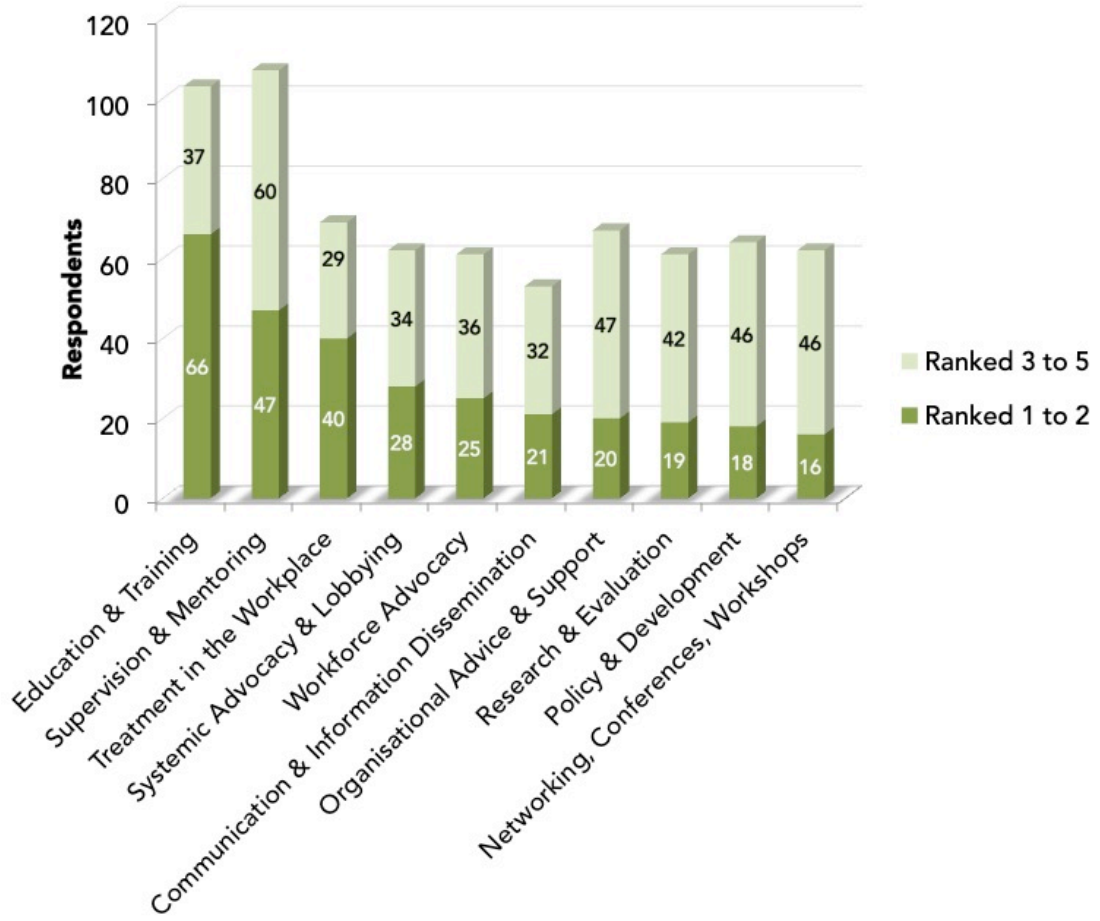
- Clubhouse International
- Intervoice International Hearing Voices Movement
- International Network of People Who Use Drugs
- International: Around the Dinner Table and F.E.A.S.T.
- International Positive Psychology Association
- European Positive Psychology Network
- PeerZone - New Zealand
- Peer Respite - USA
- Icarus Project - USA

Programs and Organisations

- Brisbane North PHN
- Metro South Health Addiction and Mental Health
- Queensland Alliance for Mental Health
- Health Consumers Qld
- Harmony Place
- Logan Central Community Mental Health
- Save The Children
- The Park Centre for Mental Health
- Wesley Mission
- Mt Gravatt Community Centre
- Psychiatric Revolution
- Police Liaison Officers
- Centre of Perinatal Excellence (COPE)
- Partners In Recovery
- Acts 2 Alliance

Priority Roles for a Peak Body

To enable Q-LEWN to identify priority areas for the next 2-3 years, respondents were asked to rate ten potential action areas in order of importance (with a rating of 1 being the most important and 10 being the least important). 150 respondents answered this question.



Other Key Areas

54 respondents answered the question "Are there any other key areas that you would like to tell us about that should be on the list?" Comments are listed below and themed into

- Peak body operational considerations
- Workforce development issues
- Other systemic advocacy issues

Peak body operational considerations

Lived Experience workers need to decide and drive policy about workforce development for their sector.

A peak body led by, with and for Lived Experience workers needs to

- Advocate for people working in both consumer and carer focused roles
- Be inclusive of rural and remote regions
- Be managed by a board of Lived Experience workers
- Be transparent and accountable to its members
- Enhance the interconnectedness of Peer Workers

The peak body needs to create and promote a culture that

- Ensures acceptance of and respect for diverse views
- Promotes equality and equity
- Promotes inclusive language and recovery focused practices

"regular opportunities to offer each other a form of, essentially, professional mutual aid would be useful. It's easy to get isolated as a token peer practitioner, or to fumble through processes (e.g. how do we manage 'outing' ourselves to non-peer managers, co-workers etc)"

The peak body should enhance the interconnectedness between and with the Lived Experience workforce. Suggestions included

- Website and events calendar
- An online library/clearing house/document repository
- An online forum for peer workers
- Opportunities to complete surveys
- Link in with other non-mental health specific services (teaching, police, etc)
- Link with mental health consumer/carer peak bodies
- Connect GP & professionals to peer worker networks

Systemic advocacy issues

- State and federal government dealing with the distribution of drugs (prescription and recreational) and alcohol
- Human Rights act in Queensland

Workforce development issues

Systemic issues impacting Lived Experience workers were themed as

- Workforce recognition and validation
- Professional development
- Working conditions
- Integrating the Lived Experience workforce
- Growing the Lived Experience workforce

Workforce Recognition and Validation

- Professional recognition of and respect for Lived Experience expertise
  - Distinguishing between different Lived Experience specialist areas (Mental Health, Alcohol and Other Drugs, and Disability)
  - Ensuring equal recognition and respect for Lived Experienced Workers from different specialities – including AOD workers and/or workers with a combined mental health and disability background
- Valuing and supporting volunteers
  - Ensuring volunteer out of pocket expenses are reimbursed)
  - More volunteer interaction and support

Professional Development

- Access to opportunities for ongoing professional development
  - Effective external supervision
  - Cert IV Mental Health Peer Support Work
  - Creation of qualifications higher than Cert IV level
  - Lived Experience educators in academia
- Professional development topics
  - Emotional wellbeing and self care
  - Case studies and stories of peer work
  - Staying well at work
  - Having difficult recovery conversations with staff and management
  - Home safety
  - Personal development or public speaking

Working Conditions

- Equity for people with various disabilities
- Role clarity and role descriptions
- Career pathways including progression to leadership and management positions
- Increased opportunities to gain employment – especially in regional, rural and remote areas
- Higher pay levels
- Increased job security
- Individual advocacy for peer workers experiencing workplace harassment

Integrating the Lived Experience workforce

- Implementing recovery in business and health/clinical models
- Education for employers around developing and maintaining a Lived Experience workforce
- Addressing the ongoing prejudice and discrimination experienced in the workplace
- Encouragement of workers in non-Lived Experience roles to draw upon their own Lived Experience to inform their practice
- Staff Co-Reflection
- Sharing with other staff
- Dedicate time for team discussions, relating to work, improving or changing groups, new ideas etc
- QLD Health / Clinical Health in-service delivery and information
- Team building
- Inclusion in groups
- More resources for peer workers to undertake activities with consumers
- Funding for local support groups
- Funding to help support, activities, no funding other than paper and colour pencils and textures
- Addressing Vicarious Trauma in these roles in the work place
- Support for Lived Experience workers in the workplace
    - Lived experience support
    - Leniency for Peer workers and residents who work within a clinical environment

Growing the Lived Experience workforce

- Getting Peer Workers into hospitals
- Prison release support
- Post partum support
- Mackay Services that provide NDIS don't hire peer workers and Mackay needs to develop a workforce
- 'Lobbing for Inpatient Safe Wards' to be ongoing, and to include consumer companions feedback concerning the issue.
- Change of name from 'Consumers Companions' to 'Inpatient Peer Support Workers' (Mental Health Inpatient Hospital Workers). As naming them Peer Support Workers (name under consideration-Confuses inpatients, as the automatically link the name to what Peer Workers do in the external community, and their work description does not fit with what consumer companions do, as we work in a crisis setting, with inpatients in crisis.
- Consumer Companion Role Description updated State wide, with consumer companion involvement.

- END -

Appendix 3: Q-LEWN 2018 Strategic Planning Report

Q-LEWN

QUEENSLAND LIVED EXPERIENCE WORKFORCE NETWORK

STRATEGIC PLANNING OUTCOMES 2018

BROOK red recovery empowerment development PEER SUPPORT

phn BRISBANE NORTH An Australian Government Initiative

ACKNOWLEDGEMENTS

This project was initiated and funded by Brook RED and Brisbane North PHN and supported by the Lived Experience Leadership Roundtable.

We acknowledge and pay respect to Aboriginal and Torres Strait Islander peoples as the traditional custodians of the land and waters on which we live, work and play.

We would also like to acknowledge and thank

- The members of the Lived Experience Leadership Roundtable for their ongoing support in working towards ensuring that Lived Experience workers drive workforce development for the Lived Experience sector and for their contributions in progressing the strategic planning workshop.
- The Lived Experience workers who participated in the workshop.
- Matt Halpin who facilitated the workshop and initially collated the perspectives from participants.

GLOSSARY

Q-LEWN adopts the definitions of Lived Experience and the Lived Experience workforce included in the *Queensland Framework for the Development of the Lived Experience Workforce.*

Lived Experience - a social experience of life changing mental health challenges and successes, service use, and periods of healing and learning. We use the term Lived Experience to include both past and ongoing challenges.[1]

Lived Experience is defined as including experiences as a consumer and/or as a carer/family member. We acknowledge that these experiences are distinctly different and inform different perspectives and priorities that can conflict.

Consumer

A person who uses mental health services for support to manage their own experience of episodes of extreme psychological distress; suicidal thoughts and/or attempts; and/or problematic substance use.

Carer/Family member

A person who has regularly provided unpaid, care or support, for a person living with episodes of extreme psychological distress; who has considered, attempted or completed suicide; and/or who experiences problematic substance use.

[1] Byrne, L., Wang, Y., Roennfeldt, H., Chapman, M., Darwin, L. Queensland Framework for the development of the Mental Health Lived Experience Workforce. 2019, Queensland Mental Health Commission: Brisbane

TABLE OF CONTENTS

Executive Summary

On behalf of the Roundtable, Brook Red and Brisbane PHN North initiated and funded further sector-wide consultations to enable LE workers to inform the development of a peak body to represent their interests. The Building Foundations Forum (attended by over 70 Lived Experience workers from across Queensland, expressed strong support the Roundtable to seek to establish a Lived Experience workforce peak body. Subsequently the Q-LEWN Survey 2018 and the strategic planning workshop sought to guide the Roundtable in progressing action to establish Q-LEWN as a peak body to represent the Queensland Lived Experience Workforce.

Themes emerging from the strategic planning workshop reinforced the survey outcomes. Foremost a strong desire was expressed by LE workers to drive the focus and direction of workforce development of their practice.

The priority areas of action for Q-LEWN emerged as

1. Sector Leadership
    - Consult with and represent the workforce
    - Champion the Lived Experience workforce
    - Support the workforce
    - Disseminate Information
    - Promote networking

2. Education and training
    - Promote and facilitate accredited training and ongoing professional development
    - Promote and facilitate supervision and mentoring

3. Advocacy
    - Lead processes for enabling a collective voice for the Lived Experience workforce
    - Advocate to government and other decision makers to advance Lived Experience workforce agendas
    - Influence and undertake research and policy development

The strategic planning workshop confirmed membership should be inclusive of the diversity of the Lived Experience workforce and be multi-tiered to offer membership options to both individuals and organisations.

BACKGROUND

The Lived Experience workforce includes people employed specifically to

- Use their Lived Experience to assist others or inform work in advocacy; management; policy and service development; education; and/or research.
- Use their life-changing experience of supporting someone through mental health challenges, service use and periods of healing/personal recovery, to assist others

The Lived Experience workforce includes consumer consultants; carer consultants; experts by experience; peer support workers, carer peer workers; cultural peer support workers, specialist peer workers and various designated Lived Experience roles in executive governance, board and committee representation, education, training, research, consultancy, policy design and systemic advocacy across a variety of service settings. Workers include full time, part-time, casual, volunteers and students studying Certificate IV in Mental Health Peer Support or relevant courses with an interest in a career as a Lived Experience worker.

The National Mental Health Recovery Framework defines peer support as people with a Lived Experience supporting each other in their recovery journey. Support may be formal or informal, voluntary or paid. It may be stand-alone support or part of an initiative, program, project or service, which is run either by peers themselves or by professional mental health service providers.[2]

Non-designated roles in mental health, alcohol and other drugs services, allied health or other relevant professions include psychiatrists, psychologists, mental health nurses, social workers, Occupational Therapists, case managers, case workers, community support workers and others. People working in these roles may identify privately or publically as having a Lived Experience, but they are not employed specifically to work from a Lived Experience perspective. People with a Lived Experience working in non-designated roles are often greatly valued as champions and allies, but they are not recognised by Q-LEWN as members of the Lived Experience workforce.

For almost a decade, government policy and industry standards have repeatedly advocated the need for Lived Experience (LE) workforce development, including

[2] Commonwealth Department of Health and Aging (CDHA). (2013). *A national framework for recovery-oriented mental health services: Policy and theory*. Retrieved 4/3/2014 from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovpol

career pathways linked to nationally recognized vocational qualifications.[3] [4] [5] [6] [7] [8] Despite this, in 2017 research funded by the Queensland Mental Health Commission (QMHC)[9] identified that there has been little systematic workforce development to date. As such the expansion and evolution of the workforce is largely ad hoc, highly variable and influenced by the degree of commitment by managers in individual organisations.

In response to issues raised by the QMHC funded research, Brook RED and Brisbane North PHN established the Lived Experience Leadership Roundtable to discuss potential for responsive action. Subsequently, the *Building Foundations Forum* included was held in May 2018 to broadly engage the LE workforce in conversations about workforce development. Over 70 delegates from across Queensland attended the Forum and highlighted strong support to create "a peak body or governing authority to tackle issues including standards, accreditation, recruitment, training, evolution of leadership, resources, supervision, equitable pay, career progression, ongoing research, stability of LE roles, and recognition that specialised LE roles exist to meet specific needs of diverse target groups"[10].

Consequently, Brook Red and Brisbane PHN North resourced the Roundtable to undertake further consultation to enable LE workers from across the state to inform the development of a peak body to represent their interests. This included the distribution of the *Queensland Lived Experience Workforce Network (Q-LEWN) 2018 Survey* and a one-day strategic planning forum held in Brisbane on the 27th of November, 2018.

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[3] Council of Australian Governments (COAG). (2012). The Roadmap for national mental health reform 2012 – 2022.

[4] Queensland Government. (2008). Queensland Plan for Mental Health 2007-2017. Queensland Health, Brisbane. Retrieved from http://www.health.qld.gov.au/mentalhealth/abt_us/qpfmh/default.asp

[5] Commonwealth Department of Health and Aging (CDHA). (2013). *A national framework for recovery-oriented mental health services: Policy and theory*. Retrieved 4/3/2014 from http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovpol

[6] Department of Health (2015) *Australian Government Response to Contributing Lives, Thriving Communities – Review Mental Health Programmes and Services;* Commonwealth of Australia, Department of Health, Canberra. Retrieved 26/3/2016 from https://www.health.qld.gov.au/ahwac/docs/min-taskforce/ministerial-taskforce-report.pdf

[7] Commonwealth Department of Health and Aging (CDHA). (2009). Primary Health Care Reform in Australia; Report to Support Australia's First National Primary Health Care Strategy. Attorney Generals Office; Barton, ACT.

[8] Commonwealth Department of Health *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Peer Workforce role in mental health and suicide prevention.* https://www1.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools

[9] Byrne, L., H. Roennfeldt, and P. O'Shea, (2017) *Identifying barriers to change: The lived experience worker as a valued member of the mental health team. 2017*, Queensland Mental Health Commission: Brisbane.

[10] *Queensland Lived Experience Workforce Building Foundations Consultation Report* (2018) Brook RED and Brisbane North PHN

PROCESS

The forum was attended by 63 people from across the state, employed in a variety of LE roles and organisations. CEO of Brook RED, Eschleigh Balzamo, welcomed participants and briefly explained the background that had led to organising the Q-LEWN strategic planning day, before introducing Matt Halpin (of Matthew Halpin Consulting and Training) as the facilitator for the event. Matt briefly presented key learning of enablers and barriers in establishing a consumer peak body in South Australia and the initial results of the Q-LEWN 2018 Survey. (Survey results detailed in a separate report available on the Q-LEWN website)

Throughout the day, participants discussed key questions in small groups, scribing their comments to butchers' paper. Small group discussions explored

- Why are we here?
- What do we want to achieve?
- Who does Q-LEWN represent?
- How does Q-LEWN represent the workforce?
- Enablers - Why do we need Q-LEWN?
- Barriers – Why we don't need Q-LEWN

Following the group discussions, participants were asked to identify their individual perspective on the priority of potential Q-LEWN activities under the headings

1. An essential activity that is core purpose
2. An important activity of organization but not an immediate priority or 100% core to purpose
3. A good idea for future planning but not core to the work of the organization

Finally, a silent ballot offered participants the opportunity to vote for or against establishing Q-LEWN. 98% of participants voted for progressing plans to establish Q-LEWN as an independent peak body.

Information collected from the day was collated into an initial compilation report drafted by Matt Halpin, and is the basis of this summary report.

Outcomes

Comments from small group discussions or individual reflection were recorded to butchers' paper or sticky notes by participants and themed as below.

Who Q-LEWN represents?

The below comments were recorded by small groups discussing the question 'Who does Q-LEWN represent?"

Identified Lived Experience workers

- Lived Experience workers defined as people working in an identified Lived Experience roles
- Identified and using LE & recovery is part of role – bring expertise to role
- Authentic and owned

Diversity across the workforce

- A broad base of LE workers, but always authentically working into our genuine peerness
- A diversity of voices/perspectives that are more representative of the whole Workforce LE and others wanting to get into it
- Full time, part time and casual
- Must live and work in Queensland
- Is it just MH, AOD, SP other specialists
- Consumers and Carers
- Individual, organization, and allies – options /types of membership
- NDIS package – purchasing LE workers
- Represents Consumer and Carer workers
- Peer Service providers
- For consumers
- For carers
- For workers
- For lived experience
- For the silent worker
- Volunteer peer workers
- Peer Work students

How Q-LEWN represents the Lived Experience workforce

The below comments were recorded by small groups discussing the question "How does Q-LEWN represent the workforce?"

By with and for the Lived Experience workforce

- Authentically owned and run by people with lived experience
- Protecting the lived experience & shared experiences through influencing policy and procedures with impact'
- Protecting the role
- Protection of role (eg NDIS)
- Represents diverse identities
- Leadership for lived experience workforce
- Leadership development
- Raising awareness for the workforce
- A chapter in each primary health network

Tiered membership structure

- Tiers of membership and association – sources of $
- Individuals, organizations and allies (different membership types)
- Individual and organisation and allies – options /types of membership

Representation through action

- Policy development
- Advocating for funding and Peer work development
- Ensuring quality training through an accreditation type process
- Providing training
- Networking events
- Conferences
- Mentoring
- Shifting cultures

Purpose and intent

The below comments listed under 'purpose and intent' were recorded by small groups discussing the questions

- Why are we here?
- What do we want to achieve?
- Enablers - Why do we need Q-LEWN?

1. Sector Leadership

Consult with and represent the workforce

- To shape and hold vision of future for peer work
- To assert that LE must drive the shape of LE work
- To make our community stronger
- To have structures/safeguards our work
- Owned, managed and driven by Lived Experience
- Belongs to members
- Facilitate rural/regional access

Disseminate Information

- Central place for communication and information dissemination
- Share knowledge and resources
- Hosts online forums
- Promote the benefit of collected knowledge, wisdom information
- Provide a point of contact for employers
- Database- 'yellow pages' for LEW
- LE specific tools and resources

Champion the Lived Experience workforce

- Raising profile
- Recognition for our profession
- Lived experience truly valued and not seen or treated tokenistically
- Understand/recognise LE as professional by clinicians
- Not just 'institutional 'D' voice
- Not 'us and them' - professional understanding
- Value, legitimacy and integrity
- Lived experience workers embedded at all levels
- Growth in the sector
- Support growth of workforce
- Continued development

Workforce support and development

- Lack of leadership can be overcome better with support
- Support for other peer workers
- Community of practice and support
- Support
- Sector wellbeing
- Further sector wide access and development of training, supervision
- Growth – have to work how to grow in principles/safe/sustable;high quality way/valid/credible
- Workforce development through a center of training
- Accountability for workforce
- Standards of practice
- Standards for the workforce (professionalism)
- Framework for Lived Experience Workforce
- A Framework for employers
- A baseline expectation – inclusive of skills and knowledge
- Provide some structure/overriding principles
- Guiding principles
- Definition of roles (consistency & continuity)
- Professionalism
- Code of ethics
- Credentialing
- Safe practice/accountable
- Complaints mechanism
- LE all levels (exec) and types
- Authenticity

Promote networking

- Connection, engagement, training, opportunity
- Networking events or communities of practice
- Networking events and conferences
- Connecting our network
- Community of practice and support
- Connects rural and remote communities
- Access to info/people
- Create change/hope
- Combined experience
- Reduce isolations of the workers
- Build on previous learning / share forward
- Lived experience conference
- One stop shop

2. Education and training

Promote and facilitate accredited training and ongoing professional development

- Endorsing training and ensuring quality of professional development for LEW
- A central body of knowledge and training
- Having a go to access resources, training and professional development
- LE Quals at higher levels
- LE and other prof qualifications
- Provides placement opportunities of students
- Education for the public

Promote and facilitate supervision and mentoring

- Access to connecting, mentoring
- Opportunities for mentorship, growth, connectedness

3. Advocacy

- Advocacy
- Systemic advocacy
- Advocacy and Systemic change
- Systemic advocacy/unified voice
- To influence
- To facilitate change
- For change
- Systemic change
- Cultural change in whole systems
- To support equity responses

Lead processes for enabling a collective voice for the Lived Experience workforce

- Facilitates inclusion/engagement across the sector/at all levels
- Unify and collaborate
- Voicing workforce needs
- Collective voice
- Awareness and voicing our needs
- Strong unified voice
- Diversity /more voices
- Voice louder together
- Strength in numbers / identity
- Easily divided and conquered

Advocate to government and other decision makers to advance Lived Experience workforce agenda

- Hold other bodies to account
- Advice to employers
- HHS/NGO – local peeps
- Equality and inclusivity
- Increases in funding
- Improved working conditions
- Wage equality and employment rights
- Sustainability for the workforce
- Role clarity and consistency
- Fair working conditions
- Remove tokenism
- Fight stigma
- Promotion of personal recovery

Influence and undertake research and policy development

- Influencing policy
- Policy development of workforce statewide
- Research/evidence – but our way
- Supporting and conducting research
- Issuing statement of position

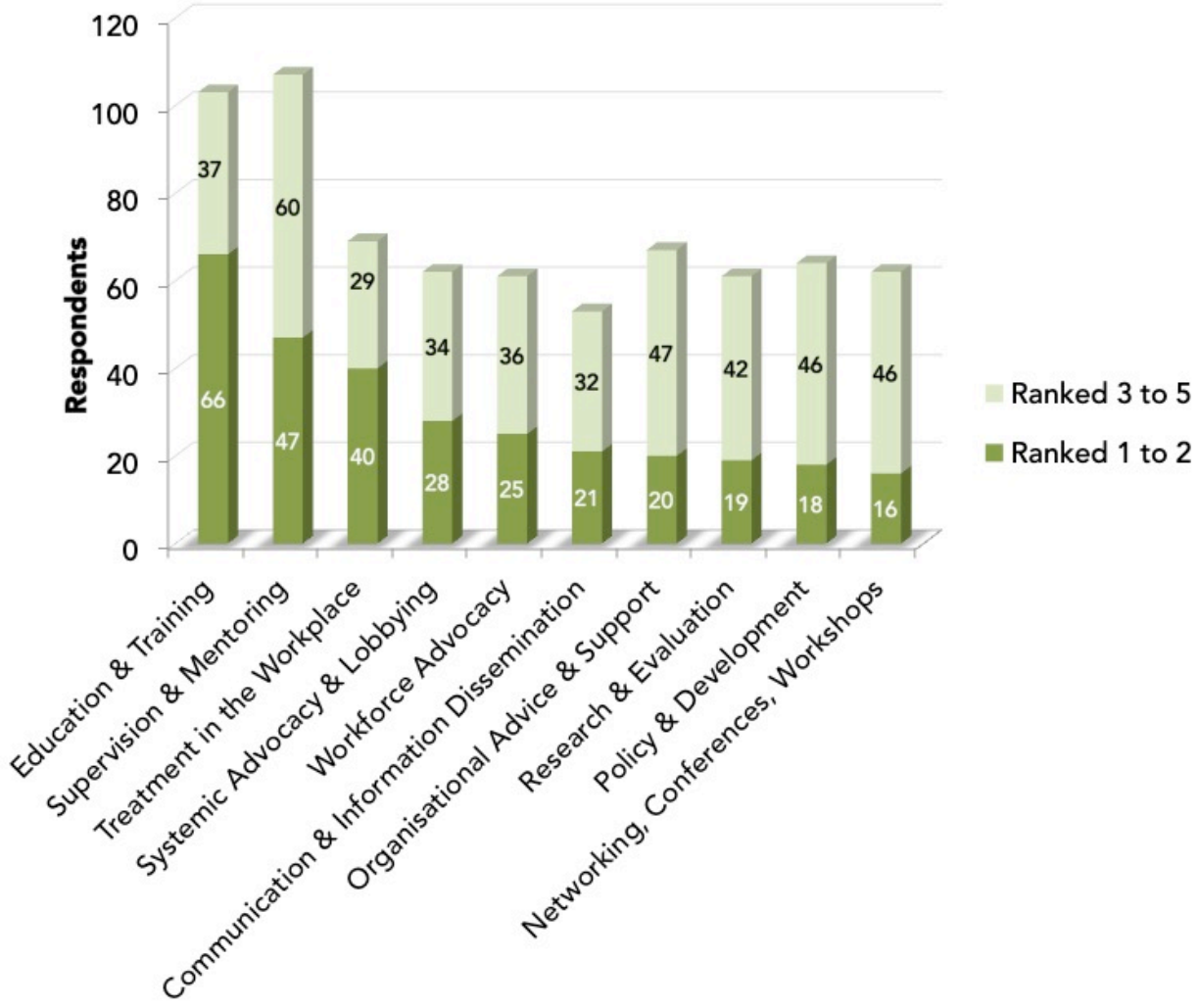
Priority Activities

Following the small group discussions, participants were asked to individually identify key activities that they thought were core to the purpose of Q-LEWN; write them on sticky notes; and post according to their perception of the level of priority (ie 1. core to Q-LEWN's purpose; 2. not an immediate priority; or 3. an idea for future planning).

Theme	An essential activity - core to Q-LEWN's purpose	An important activity - not an immediate priority	A good idea for future planning
Sector Leadership	Lived Experience leadership development		
Champion the LE workforce	Legitimizing the LE workforce Add value and integrity to workforce	Promoting LE work as a credible, viable option Representation for peer workers in other areas – AOD, HIV, etc	Promoting LE workforce development and pathways Increasing credibility and visibility of workforce Sustainability and funding of workforce
Disseminate Information	Information and communication dissemination		
Workforce support and development	Set industry standards and policy Professional standards for workforce Develop, implement and evaluate a LE workforce framework Articulating practice Career pathways	Defining the niche for lived expertise work Define core skills to validate Credentialing of workforce CPD accreditation program for training Identifying communities	Regulation

Theme	An essential activity core to Q-LEWN's purpose	An important activity not an immediate priority	A good idea for future planning
Promote networking	A network and community of practice for LE workforce	Improving communication and collaboration across public, private and NGO Networking Ideas exchange	Developing local communities of practice
Promote and facilitate supervision and mentoring	Mentoring and external supervision		
Promote and facilitate accredited training and ongoing professional development	Education and training	Inclusive of natural and informal peer support	Training accreditation Create education beyond Cert IV Education for the public
Advocacy	Systemic advocacy, lobbying and change Unify our voice Collective identity and voice	Improvement of mental health services	Platform for collective action Influence policy and planning from QMHC and DOH Provide a voice for the voiceless Stigma reduction
Influence and undertake research and policy development			LE workforce research Sector mapping and promotion

The above prioritised activitives are consistent with the below results from the Q-LEWN Survey 2018, completed by 151 Lived Experience workers.



Barriers

The below comments were recorded by small groups discussing the questions "What are the barriers? Why don't we need Q-LEWN?"

Operational

- Difficulty to operationally manage
- Who's going to do the work- Operational management
- Quality control
- Costs including economic sustainability
- Bureaucracy/red tape
- How will it be kept accountable
- How will it benefit the people
- How will it stay current
- How much power will it have compared to other professional bodies

Managing diverse interests

- How potential conflicts of interest are managed
- Consumers vs Carer or both?
- NGO vs Government
- Different peer frameworks
- Too hard and too many agendas
- How do we keep out cowboys?
- Too many eggs in one basket
- Won't accurately represent all voices
- Potential conflicts

Risks

- Too soon
- Could create an us and them
- Recreating power structures we fight against
- Corporate face to a human practice

Appendix 4: Queensland Framework for the Development of the Mental Health Lived Experience Workforce

Queensland Framework

for the Development of the

Mental Health Lived Experience Workforce

Queensland
Mental Health Commission

Purpose of the framework

The purpose of this framework is to support the development and expansion of lived experience roles across Queensland. It is intended to be broad, flexible, adaptive and evolving over time. The framework seeks to strengthen understanding and collaboration across the mental health sector and contribute to more effective services and better outcomes for people accessing services.

The framework is a tool to assist and guide organisations across sectors and along all stages of lived experience workforce development. It is anticipated the framework will provide a guiding document for widespread use in the public, non-government and private sectors to inform development of the lived experience workforce and improve lived experience employment and collaboration within mental health settings.

The framework is comprised of a suite of resources that together provide a comprehensive package to cover different aspects of lived experience workforce development and provide guidance to identify effective lived experience practice and employment.

- The framework aims to increase understanding of lived experience value and functions and provide clear information for organisations on how to structure and support lived experience roles.
- The Summary provides a brief overview of the framework.
- The Poster provides a snapshot of the key focus areas of the framework that can act as a handy reference in the workplace.
- The *Role Titles and Descriptions for Mental Health Lived Experience Workforce Development* document provides a guide to assist organisations to design meaningful lived experience roles and can be used in conjunction with the framework.
- The *Queensland Framework for the Development of the Mental Health Lived Experience Workforce* report provides greater detail of the process, reference lists of literature that informed the work, detailed literature mapping and summaries of the survey data.

All documents in the package are available for download from the Queensland Mental Health Commission's website: **qmhc.qld.gov.au/engage-enable/lived-experience-led-reform/peer-workforce**

Our collective hope is that organisations not only access and endorse the framework package but also proactively seek and create opportunities to work together, share resources and learning.

Contents

Acknowledgements

We acknowledge, value and thank people with a lived experience and others who contributed in the co-design of this Framework through sharing their time, expertise and advice in a variety of ways, including through participation in focus groups, surveys, and advisory and governance groups.

We wish to pay respect to Aboriginal and Torres Strait Islander Elders, past, present and emerging, and acknowledge the important role of Aboriginal and Torres Strait Islander peoples, their culture and customs. In doing so, we acknowledge the unique and diverse cultures of Australia's First Nations people. This includes the distinct differences between Aboriginal cultural practices and protocols and those of Torres Strait Islander peoples.

We demonstrate our pledge and commitment to closing the gap in Aboriginal and Torres Strait Islander peoples' mental health and do so by supporting the Gayaa Dhuwi (Proud Spirit) declaration. The leadership, cultural practices and expertise of Aboriginal and Torres Strait Islander peoples across all parts of the Australian mental health and suicide prevention sector is critical to improving outcomes.

https://natsilmh.org.au/sites/default/files/gayaa_dhuwi_declaration_A4.pdf

We acknowledge people with a lived experience of mental health, alcohol and other drug challenges, their families and significant others. We stand in solidarity, with hope that anyone may go on to live a purposeful and meaningful life of their own choosing. We give particular acknowledgment to the pioneers in the lived experience, consumer and carer movement who paved the way for the possibilities that exist today.

This project was advocated for by lived experience leaders, funded by the Queensland Mental Health Commission and led and co-produced by researchers who identify as having a personal lived experience of significant mental health challenges, service use and periods of healing.

Suggested citation

Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L. Queensland Framework for the Development of the Mental Health Lived Experience Workforce. 2019, Queensland Government: Brisbane

Factors that drive the need for the framework

The potential benefits of lived experience workers are many and varied, with value identified for organisations, colleagues and people accessing services.

Benefits for people accessing services

- Mutuality
- Increased empathy
- Foster a sense of belonging/community
- More equitable relationships
- Lived understanding aids trust
- Living example of hope
- Rapport/connection
- Advocacy

Benefits for all

- Hope and optimism
- Greater wellbeing and inclusion
- Reduced need for ongoing formal support and hospitalisation

Benefits for organisations and colleagues

- Contribute to more person-directed services
- Contribute to greater recovery understanding/orientation
- 'Bridge' of understanding between people and accessing services and colleagues in traditional roles
- Contribute to more positive/inclusive/flexible work culture

Respecting and valuing lived experience in the mental health workforce is broader than just designated lived experience roles. It provides depth to person-directed approaches by acknowledging the expertise each individual holds regarding their own life and mental wellbeing. It can also promote a workplace culture in which it is safe for people in non-designated roles to disclose.

Meaningful inclusion of lived experience workers provides strong alignment with an ongoing service transformation agenda and efforts including *The Fifth National Mental Health and Suicide Prevention Plan*[1] and *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023*[2] and is seen to provide a benchmark for contemporary, recovery-orientated, person-directed service delivery.

However, the employment conditions and outcomes for lived experience work are highly variable and 'ad hoc'. While current national and state guidelines strongly recommend further development of lived experience work, there is currently no accountability or auditing. Additionally, lack of exposure to and understanding of the roles often impacts the perceived value or acceptance of roles. A lack of award wage, union or dedicated peak body also impacts negatively on the working conditions of many. Consequently, both lived experience workers and organisations face challenges embedding this still emerging workforce. Due to the challenges identified, there is a call for greater structures and formalisation of the lived experience workforce to ensure equity, but which still allow for essential flexibility within individual roles.

1 Council of Australian Governments, *The fifth national mental health and suicide prevention plan.* 2017, Canberra: Commonwealth of Australia **www1.health.gov.au/internet/main/publishing.nsf/Content/mental-fifth-national-mental-health-plan**

2 Queensland Mental Health Commission, *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023.* 2018, Brisbane: Queensland Mental Health Commission **qmhc.qld.gov.au/shifting-minds**

Approach to developing the framework

Background

In November 2017, a group of lived experience leaders from across Queensland organised a one-day workshop to discuss lived experience-led research findings[3] in relation to lived experience workforce development and consider implications for the state.

Following this event, these leaders provided a position paper to the Queensland Mental Health Commission (the Commission) outlining the recommendations they felt should be prioritised. Following discussions it was determined that developing a framework to assist organisations to implement the research findings was the key strategic priority.

Confirming the key focus areas

Findings from three lived experience-led qualitative studies[4] provided the initial data to inform the Queensland framework. These studies included the perspectives of lived experience workers in a wide variety of roles and across sectors, people employed in senior management and executive roles, non-designated mental health roles and corporate roles. A reference list including publications from these studies is provided in the *Queensland Framework for the Development of the Mental Health Lived Experience Workforce* report available at: **qmhc.qld.gov.au/engage-enable/lived-experience-led-reform/peer-workforce**.

Key focus areas for the framework were determined by comparing the findings of the previous qualitative research to the priorities of the Strategic Forum. Where gaps were identified, questions to the Advisory Group *(see page 6)* and sections of the quantitative survey sought to address these gaps.

After ethical approvals were granted, the quantitative survey was distributed to employees in the mental health sector across Queensland. The survey questions focused on testing and confirming the previous qualitative findings and expanding knowledge of the current Queensland workforce from various perspectives. In total, 496 employees across different roles completed the survey. The survey responses contributed additional information regarding role clarity, understanding and collaboration between lived experience and other roles, flexibility in the workplace, role titles, functions and role descriptions.

The focal points were then mapped against comparable documents nationally and internationally. Seventeen international documents and 30 Australian documents were scanned to identify major themes relating to the lived experience workforce and verify the key focus areas. Table 1 in the Appendix provides a summary of the key themes mentioned in the documents and the context in which they were mentioned. For full details of the literature mapping including a full list of documents, or to learn more about what informs the framework, the report on the project is available at: **qmhc.qld.gov.au/engage-enable/lived-experience-led-reform/peer-workforce**.

3 Byrne, L., H. Roennfeldt, and P. O'Shea, *Identifying barriers to change: The lived experience worker as a valued member of the mental health team*. 2016, Queensland Mental Health Commission: Brisbane.

4 Ibid.

Byrne, L. *A grounded theory study of lived experience mental health practitioners within the wider workforce*. 2014, Central Queensland University: Rockhampton.

Byrne, L. *Explore the factors that support effective employment of peer roles within multidisciplinary mental health service delivery*. 2018, Fulbright Commission.

Approach to developing the framework

Participation and engagement strategies

In addition to the framework being led and co-produced by lived experience researchers, a variety of groups and individuals were involved in developing and contributing to this framework.

Lived Experience Workforce Strategic Forum

A Strategic Forum group consisting of key lived experience workforce leaders provided governance for the project in partnership with the Commission. The Strategic Forum included lived experience leaders and allies from key organisations across the sector and the state, including a Primary Health Network representative (PHN), Queensland Government, non-government and lived experience-led organisations. Members of the Forum provided guidance and direction, collectively contributing to key decisions.

Advisory Group

To ensure broader participation by the lived experience community, an Advisory Group was formed from members of the 'Lived Experience Roundtable'—a group of lived experience leaders with interest in contributing to strategic decision making for the state. 'Leadership' has been defined broadly as "people with influence and/or passion" and includes emerging leaders. The Advisory Group provided information on key areas of the framework, particularly relating to the priorities from a workforce perspective, role titles/descriptions and functions. The Advisory Group also provided emerging best practice examples to include 'real world' illustrations of the key areas of the framework in action across Queensland.

Survey

The survey allowed opportunity for input from a range of 'grass roots' stakeholders across the state, including lived experience workers in diverse roles and sectors, people in non-designated mental health roles, people in various management roles, people in corporate roles, including human resources and administrative positions. A total of 496 employees from across the Queensland mental health sector completed the survey.

Focus groups

Focus groups similarly aimed for grass roots contribution and feedback across roles, sector and state. A total of 146 people attended focus groups, which were held in a variety of regions across the state including three metropolitan, five regional, one rural/remote and one Indigenous specific consultation. The format for the focus groups was co-designed by a lived experience research team member and an Indigenous cultural advisor. Focus groups were led by local facilitators with a strong understanding of their community and the services in that community. Facilitators and participants were sent electronic copies of the draft framework several weeks prior to the focus groups.

Other input

Contribution to the development of the framework was also specifically sought from people working in Lived Experience of Suicide and Lived Experience of Alcohol and Other Drugs roles.

Approach to developing the framework

Cultural diversity and inclusion strategies

The section in the framework on diversity and inclusion was led by an Indigenous cultural advisor. The Indigenous cultural advisor also provided guidance, input and feedback on the overall document, including at the conceptual stages of the framework and successive drafts. Another Indigenous cultural advisor provided guidance on the design of focus groups and led the Indigenous-specific engagement.

Cultural advisors from the Queensland Transcultural Mental Health Centre, including people employed in lived experience roles, also contributed to writing the Inclusive Culture section and provided feedback on the overall document during successive drafts.

A member of the research team who identifies as LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual) and has conducted research specifically relating to LGBTQIA+ experiences, provided insight and input from an LGBTQIA+ perspective.

Other lived experience roles

Roles relating specifically to a lived experience of alcohol and other drugs are still evolving in Queensland and much of Australia, but there are already established positions across Victoria. The Department of Health and Human Services recently launched *A Strategy for the Alcohol and Other Drugs Peer Workforce Victoria*: **sharc.org.au/wp-content/uploads/2019/07/AOD-SHARC-Workforce-Strategy-web.pdf**.

Currently, a lack of designated funding and pervasive stigma create barriers for the development of the alcohol and other drugs lived experience workforce. However, it is envisaged that many of the strategies in this framework will be relevant to the development of alcohol and other drugs lived experience roles.

Although lived experience of suicide roles are not explicitly covered by this framework, many of the concepts are transferable and a framework specific to the lived experience of suicide space can be accessed at: **https://blackdoginstitute.org.au/docs/default-source/lifespan/2019_bdi_rural_report_220_final_int.pdf?sfvrsn=2**.

Language and definitions

In the lived experience, peer, consumer, service user, survivor movement, various terms are used to describe similar experiences and roles. We recognise that one label, category or description will not be able to capture the breadth of individual experiences and preferences. We support multiple perspectives as an essential element of this work and have selected particular terms and phrases simply for ease of understanding throughout the document, not to impose these choices. We provide some explanations and definitions for our choices below. We have sought to be inclusive and apologise for any unintended offence.

Similarly, we use the acronym LGBTQIA+. We recognise that one label, category or description may not be able to capture the breadth of the LGBTQIA+ community. Our intention is to be inclusive of everyone and we apologise for any unintended offence.

We use the term ‘mental health challenges’ in this document as ‘challenges’ seems to suggest a situation that may be overcome. However, we recognise there are different preferences and choice is important for individuals in describing their own experience.

We acknowledge that Western ways of describing mental health can conflict with cultural beliefs. We have used the term ‘mental health’ for easy identification of concepts within the mainstream health system. We also acknowledge and respect different preferences for describing experiences and the meaning and connection language holds within diverse cultures.

The term ‘lived experience’ is seen to include both ‘consumer’ and ‘carer’ perspective roles and to provide an umbrella term for the many designated lived experience informed roles that exist. We acknowledge that ‘consumer’ and ‘carer’ roles are inherently different, with different perspectives and priorities that at times can be conflicting. These roles are distinct and the inclusion of both is not intended to suggest otherwise.

Approach to developing the framework

For the purposes of this framework, lived experience roles are defined as people employed specifically to:

- use their personal understanding of life-changing mental health challenges, service use and periods of healing/personal recovery, to assist others
- use their life-changing experience of supporting someone through mental health challenges, service use and periods of healing/personal recovery, to assist others.

The lived experience workforce includes consumer consultants; carer consultants; experts by experience; peer support workers; carer peer workers; cultural peer support workers; specialist peer workers; and various designated lived experience roles in executive governance, board and committee representation, education, training, research, consultancy, policy design and systemic advocacy across a variety of service settings.

Specialisation is raised many times within this document and recommended when it may be most effective in supporting people from diverse backgrounds and experiences. Specialisations are specifically listed for:

- Aboriginal and Torres Strait Islander peoples
- people from culturally and linguistically diverse backgrounds
- people from the Deaf community
- people identifying as LGBTQIA+
- people with a history of trauma and/or family violence
- people with experiences of perinatal mental health
- people with experiences of eating disorders
- people with experiences of suicide
- people with experiences of involuntary treatment, incarceration and/or homelessness
- people with experiences of alcohol and other drug use or dependence
- people identifying as neurodivergent
- people with disability
- older people
- youth
- veterans.

While we have tried to be as inclusive as possible, we acknowledge this will not be an exhaustive list. We apologise for any oversight and any unintentional offense that may be caused.

While the term ‘lived’ experience is predominantly used within this document, many people describe having a ‘living’ experience i.e. ongoing challenges. The term ‘lived’ here is intended to signify both, and is not meant to imply experiences are not ongoing.

People in non-designated roles are defined as: people who are employed in mental health or other relevant professions; allied health roles; or in non-credentialed mental health worker roles. Non-designated roles include: psychiatrists, psychologists, mental health nurses, social workers, occupational therapists, allied health, case managers, case workers, community support workers.

Many people working in roles that are not lived experience designated may still identify privately or publicly as having a lived experience, but they are not employed specifically to work from that perspective and are not classified as part of the ‘lived experience workforce’.

Key focus areas

To provide a comprehensive, detailed and workable guide to developing the lived experience workforce in Queensland, the key focus areas have been grouped into seven broad categories as shown in the diagram.

Understanding and defining roles

Lived experience roles exist in diverse organisations and contexts, spanning entry level to executive leadership roles. While it's true everyone has some 'lived experience', not everyone chooses to work in a role that is primarily informed by their lived experience.

Lived experience roles are not only informed by an individual's experience with challenge, support or even 'recovery', rather it's how those experiences are contextualised in relation to the wider lived experience movement and universal issues of marginalisation and loss of identity/citizenship. Ultimately, lived experience work is about how experiences are understood and applied to benefit others.

Key factors in defining lived experience roles and assessing if they're effective:

What defines lived experience roles?

Unique knowledge, abilities and attributes

Life-changing mental health challenges that have taken the person in a new direction and changed life as they knew it

Life-changing experiences that have profoundly impacted their life/world view while supporting someone with mental health challenges

- Personal identification with and experiences of service use and/or advocating for someone using services
- Willingness to share experiences/parts of personal story in work role
- Understanding both experiences of hopelessness and the critical need for hope—how to move from a position of hopeless to one of hope
- Willingness to be vulnerable and publicly 'out'
- Willingness to use emotional understanding and knowing as key to the work role
- Understanding of the personal impact of experiences of trauma
- The degree of empathy and what they are able to understand and empathise with
- Greater equality and efforts to reduce power imbalances with people accessing services, including no involvement with coercive or restrictive practice of any kind
- Being an advocate/change agent
- Level of awareness about self-care and skills/strategies to prioritise it

What makes lived experience work effective?

Lived expertise, not just having a lived/living experience but what has been learned through that experience and how it's applied

Links with and understanding of the wider lived experience movement and concepts including lived experience-led research/training

- Work that is values-based and authentically lived experience informed, person-directed and aligned with recovery principles
- Significant understanding and ability to use personal story effectively and appropriately for the benefit of the service user
- Convey or inspire hope, providing a living example of hope
- A bridge between organisations and people accessing services/supporting people accessing services
- Trauma-informed: awareness of the role and impact of trauma and wish to respond compassionately and sensitively
- Strengths-based, focused on the relationship/person
- Greater flexibility and ability to be responsive to the service user
- Specialisation may be useful depending on the context and experience, such as people from the Deaf community; youth; older people; people with experiences of family violence, perinatal mental health, suicide, eating disorders, involuntary treatment, incarceration, homelessness, and alcohol and other drug use or dependence; people identifying as LGBTQIA+ or neurodivergent; people with disability; veterans; Aboriginal and Torres Strait Islander peoples; and people from culturally and linguistically diverse backgrounds.

Understanding and defining roles

Emerging best practice examples

‘Lived Expertise’ Practice Framework

Mission Australia commissioned lived experience consultants, ‘Enlightened Consultants’, to develop a Lived Expertise Practice Framework to further embed their lived experience workforce within their organisation. Mission Australia recognised the importance of their lived experience workforce in making a significant contribution to Mission Australia’s organisational culture and strengthening the diversity, competence and skill set that they were able to provide to the community. The Framework provides clarity and a common understanding of what lived expertise practice means to Mission Australia and its people, while also outlining ‘lived expertise’ practice domains and guiding practice principles and practices.

Lived Experience Participation Framework

The Department of Health has developed guidelines for PHNs to support better outcomes in mental health by promoting and supporting the employment of peer/lived experience workers as part of multidisciplinary teams. These documents provide guidance on the mental health and suicide prevention peer workforce and set out a clear framework for consumer and carer participation in PHNs. This includes embedding consumer and carer participation in all aspects of the commissioning cycle and developing the lived experience workforce. In June 2018, the department supported the establishment of the National Mental Health Lived Experience Engagement Network (MHLEEN).

Additional resources

- Companion document *Role Titles and Descriptions for Mental Health Lived Experience Workforce Development*. Includes additional emerging best practice examples and detailed information on designing lived experience roles and position descriptions: **qmhc.qld.gov.au/engage-enable/lived-experience-led-reform/peer-workforce**
- Mental Health Commission of NSW Peer Work Hub offers various videos and resources to assist in lived experience workforce development: **http://peerworkhub.com.au/what-is-peer-work**
- Particularly relevant to defining and understanding lived experience work and planning meaningful lived experience positions is the *Define your purpose worksheet*: **http://peerworkhub.com.au/wp-content/uploads/2016/05/2-define-purpose.pdf**
- Resources from lived experience-led ‘Enlightened Consultants’: **http://enlightened.com.au/index.php/products-resources/weblinks-articles-papers**
- PHN Lived Experience Participation Guidelines: **health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools**
- A handy lived experience-led guide to co-production *Co-production putting principles into practice in mental health contexts*: **https://recoverylibrary.unimelb.edu.au/__data/assets/pdf_file/0010/2659969/Coproduction_putting-principles-into-practice.pdf**
- Neami Carer Framework provides guidelines for engaging with family, friends and other supports: **https://assets.neaminational.org.au/assets/Resources/Neami-National/04ea26d1d9/carer_framework_2017_web.pdf**
- ARAFMI Support and workshops for carers: **arafmi.com.au**
- Children of Parents with a Mental Illness (COPMI): **copmi.net.au**

Understanding and defining roles

Emerging best practice strategies and outcomes

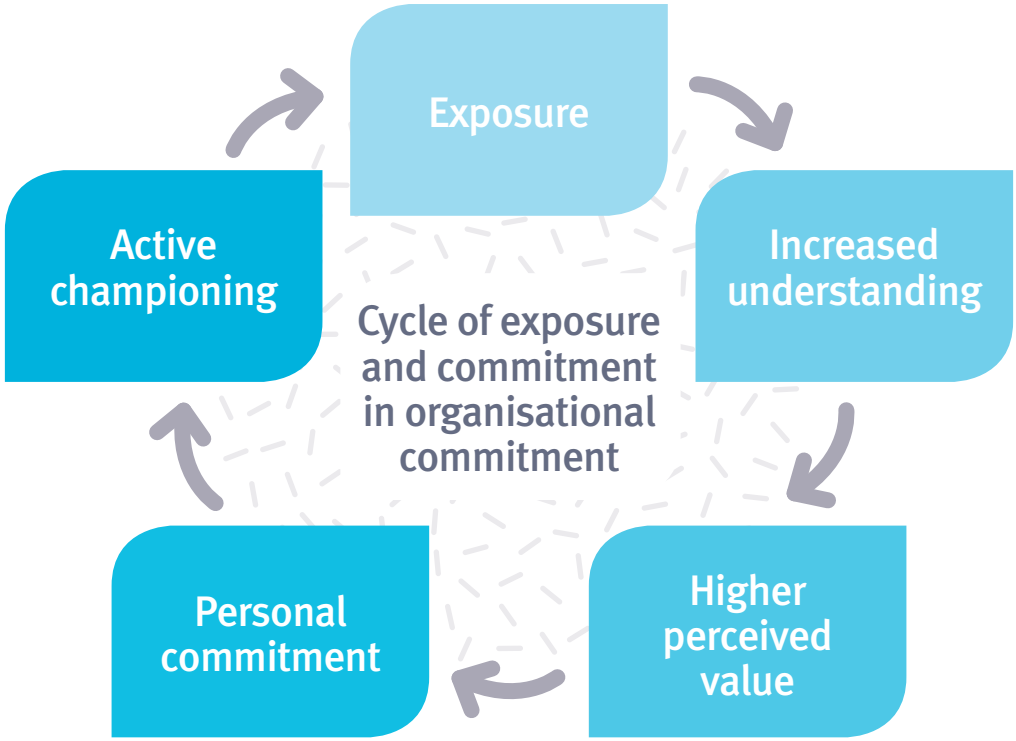
Emerging best practice strategies for understanding and defining roles	Outcomes/benefits of strategies	Issues and risks if not addressed
Exposure to lived experience concepts including exposure to lived experience leaders/peak body, lived experience-run organisations, lived experience-led publications and research	Increased understanding of lived experience roles, the potential benefits of lived experience roles, and how to design, use and support lived experience workers effectively	Lack of exposure to lived experience concepts, leaders etc. contributes to lack of understanding of the role/ benefits. This then leads to less commitment to meaningful design/ embedding of roles
Development of formal networks across the sector. Ongoing mentoring from organisations with greater experience employing lived experience	Increased motivation and action to ensure the roles are meaningfully designed, supported and embedded within organisations Includes motivation and action to ensure roles remain 'authentic'	Roles are not understood as unique and become shaped by more dominant practice, the unique benefits are reduced or lost
Develop clear, appropriate position descriptions that have considered how the role will be embedded in the wider organisation and what the outcomes of the role are likely to be. Lived experience workers are involved in the recruitment and selection process including interview panel	The 'right' person for the job is recruited, with the appropriate skills, personal and professional experience to be successful and contribute to the team	Lack of role clarity and poorly defined positions lead to inappropriate, tokenistic or inefficient recruitment processes People recruited who aren't right for the job or organisation are less likely to be successful Negative perceptions about lived experience work are created or sustained
Acknowledge, where appropriate, the advantage of similar experiences, background, orientation or identification	A lived experience workforce that has the ability to use specialised skills/experiences to promote better rapport with and outcomes for people accessing services	Lived experience workforce is not representative of the diversity of the population, perpetuating exclusion of people with diverse experiences

Understanding and defining roles

Emerging best practice strategies for understanding and defining roles	Outcomes/benefits of strategies	Issues and risks if not addressed
Acknowledge there may not be a shared understanding across cultures, particularly in relation to concepts of 'mental health', individual rights and advocacy	A lived experience workforce that is actively inclusive of Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds, people identifying as LGBTQIA+, people from the Deaf community, youth, older persons, people with experiences of trauma, family violence, perinatal mental health, suicide, eating disorders, involuntary treatment, incarceration, homelessness, alcohol and other drug use or dependence, people identifying as neurodivergent, people with disability, veterans and people with other diverse experiences	Lived experience workforce may not consider issues of intersectionality and the added impacts of culture, sexual orientation, disability, alcohol and other drug use or dependence, and other diverse life experiences may not be taken into account
Understanding that lived experience work should never be involved either explicitly or implicitly in coercive or restrictive practice	Lived experience work that is understood for its unique contribution in building relationship/rapport with people accessing services in a more equitable way without power imbalance Lived experience work is supported to be authentic	Damage to relationship/trust with people accessing services. Conflict for the lived experience worker being forced to contradict lived experience values. Lack of clarity/understanding between lived experience workers and non-lived experience roles

Organisational commitment

Organisational commitment includes philosophical and financial commitment made by organisations, particularly at executive levels. Human resources policy and processes are seen as the realisation of that commitment in practice and are covered in a later section.



Commitment to lived experience workforce development has been found to increase as exposure to lived experience roles and concepts increases. Exposure is found to foster greater understanding of the roles, which is then linked to increased perceived value regarding lived experience roles.

As perceived value and understanding increase, so do commitment, action and investment.

Conversely, less exposure to lived experience roles and concepts has been found to result in continuing negative stereotypes about lived experience work, poor understanding, limited commitment/investment and less effective lived experience initiatives/outcomes.

What does commitment to lived experience roles look like?

The organisation needs to be willing to be adaptable, flexible and open to change. In emerging best practice examples, the organisation has embraced the role of lived experience in influencing and changing work culture.

The organisation needs to make a philosophical and financial commitment to lived experience workforce development that is long-term and includes sufficient numbers of lived experience roles, sufficient full-time equivalent (FTE) allocation, adequate resources and attention to protecting the authenticity of the roles.

How to build organisational commitment

- First commit as an organisation to recovery and person-directed service delivery
- Ensure organisational values align with and promote lived experience perspectives
- Promote leadership and championing of lived experience at all levels of the organisation
- Create impactful lived experience leadership positions that are properly resourced and able to support and guide development of the wider lived experience workforce, including maintaining the integrity of lived experience roles.

Organisational commitment

Emerging best practice examples

Formal Growth Strategy

The Gold Coast Hospital and Health Service developed a *Formal Growth Strategy* for increasing their Consumer, Carer and Family Participation Team. This strategy demonstrates organisational commitment and provides impetus and direction to the Mental Health Service. The strategy also follows on from a previous *Business Case for Proposed Model of Service,* which saw peer/lived experience workers employed under long-term contracts and those in casual positions made either permanent full-time or part-time employees. This strategy calls for the service to invest in lived experience leadership, set percentage targets to grow the team and evaluate the effectiveness of the strategy.

Additional resources

- *A Toolkit for Facilitating Cultural Change* assists organisations to effectively embed lived experience work. The toolkit is central to a broader initiative providing comprehensive learning/networking and hands-on assistance. A learning collaborative provides opportunity for multiple organisations to learn 'from each other to strengthen your organisations to maximise peer/lived experience supports'. Contact: Chyrell Bellamy **chyrell.bellamy@yale.edu**
- Western Australia Peer Supporters Network Report on how to support peer/lived experience workforce growth: **comhwa.org.au/wp-content/uploads/2017/06/The-Peer-Workforce-Report-2018.pdf**
- Being's Position Statement on the lived experience workforce. Contact Being at: **being.org.au**
- Centre for Mental Health Learning Victoria, *Consumer and Family Carer Workforce Development*: **https://cmhl.org.au/peer-inside**

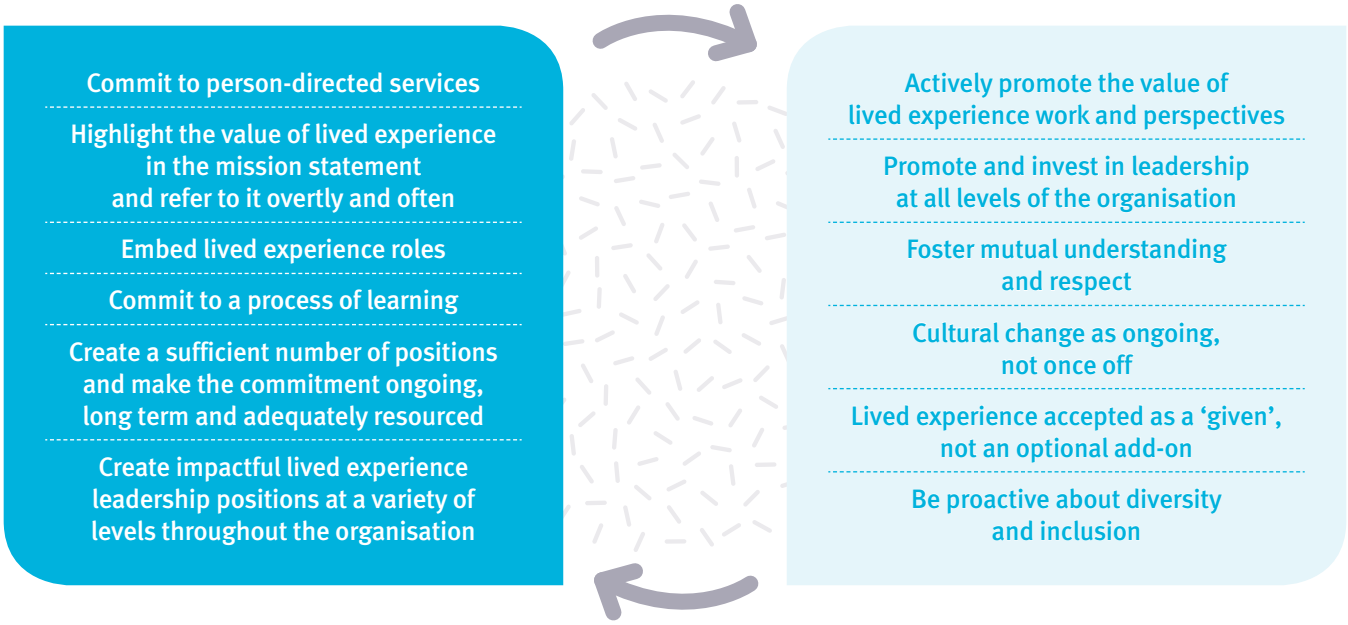
Organisational commitment

Emerging best practice strategies and outcomes

Emerging best practice strategies for organisational commitment	Outcomes/benefits of strategies	Issues and risks if not addressed
Management have exposure to 'authentic' lived experience work and become motivated to champion lived experience roles	Lived experience is valued and understood	Lack of exposure leads to lack of understanding, investment and commitment by management
Active championing by management includes advocating for positions and funding, and ensuring the uniqueness of the roles is protected	Integrity of lived experience roles maintained A sustainable and valued lived experience workforce is developed	Roles may become co-opted if the uniqueness is not understood and protected Lack of funding impacts sustainability
Lived experience workforce is developed including sufficient numbers of lived experience roles and the creation and resourcing of lived experience leadership/management positions at a range of levels throughout the organisation	Lived experience workers can support each other and assist in providing role clarity Lived experience voices in positions of influence help protect authenticity of the roles and provides career pathways	Employing one or limited numbers of lived experience workers creates professional isolation and contributes to co-option of roles (erosion of authenticity)
A long-term commitment is made, and a culture of learning, innovation and organisational self-reflection is encouraged	Lived experience roles are supported to be effective, outcomes of lived experience work are maximised	With short-term roles or lack of commitment, lived experience roles are more tokenistic/marginalised and outcomes minimised
Valuing lived experience is identified as core business within the mission statement and actively referred to	Recovery orientation is increased, person-directed practice is better understood and applied. People accessing services benefit from increased recognition and value of lived experience	
Processes and systems to support the lived experience roles are embedded as part of core business	Organisations are seen as a leaders of lived experience practice	Without these supports, lived experience roles are less likely to be effective/successful and organisation may stop employing or investing in lived experience

Organisational commitment

Organisational commitment influencing workplace culture



Workplace culture

Workplace culture is determined by the attitudes and beliefs of people in an organisation. Workplace culture is a critical factor in the success of lived experience roles. A workplace culture that genuinely views lived experience as valuable and essential allows the roles to be meaningfully embedded.

Respecting and valuing lived experience roles promotes a work and service culture of valuing lived experience. This in turn promotes more person-directed service design by acknowledging the expertise each individual has and the guidance they can bring to their own life and mental wellbeing.

Many people in non-designated roles also have a personal lived experience; however, disclosure of these experiences is still relatively rare across the sector and can pose risks to the individual. There are potential roles for lived experience workers in promoting a workplace culture in which it is safe for people in non-designated roles to disclose, including:

- Lived experience perspectives embedded into human resources practices to co-create a safe workplace for disclosure
- Lived experience-run and designed, or co-designed training on identifying with lived experience and/or coming 'out'
- Lived experience-led training to assist people in non-designated roles to learn how to use their lived experience appropriately and effectively.

Cultural barriers for lived experience roles in traditional work environments

The dominance of traditional 'corporate values' within some organisations, particularly in executive management, can adversely impact people in lived experience roles. Lived experience workers have a unique value in their relatability: for the less formal and more 'natural' relationships they form with people accessing services. However, what is a benefit in relating to people accessing services can make lived experience workers feel like a fish out of water when it comes to corporate culture.

Some lived experience workers describe a fear of 'getting it wrong' and potentially being seen as unprofessional, because of what are viewed as traditional corporate ways of being and behaving. Truly inclusive workplace culture should consider the existing cultural norms within the organisation and potential impacts on lived experience roles.

Workplace culture

Emerging best practice examples

Whole-of-workforce training/preparation and consultation with lived experience research

The Townsville offices of the Open Arms Veterans and Families counselling service consulted with lived experience research before starting their new pilot program to incorporate lived experience workers. Organisational readiness training for both management and colleagues was commissioned and delivered by the lived experience researchers who had developed and published the research. Role functions and descriptions for the new lived experience positions were considered in relation to the broader lived experience movement/research and colleagues in traditional roles were involved in this process. This pilot has been successful, with the Federal Minister for Veteran Affairs announcing lived experience workers are now planned for Open Arms services nationally.

Additional resources

- The Recovery Self-Assessment (RSA) is a self-reflective tool to identify strengths and target areas of improvement for organisations in achieving recovery-orientated service. The RSA is freely available to download from: **https://medicine.yale.edu/psychiatry/prch/tools/rec_selfassessment/**
- Research on the barriers and enablers to the employment of people with a lived experience (peer workers) in the mental health sector can be accessed at: **qmhc.qld.gov.au/engage-enable/lived-experience-led-reform/peer-workforce**
- Lived experience-led research on a range of workplace issues including workplace culture can be accessed at: **researchgate.net/profile/Louise_Byrne2**
- *Far North Queensland (FNQ) Peer Workforce Framework* is designed to provide direction to policy makers, decision makers, organisations and peer workers. Contact Centacare Far North Queensland at: **centacarefnq.org**
- *SHARC Organisational Readiness Training* for organisations looking prepare their organisations for a peer workforce: **sharc.org.au/peer-support**
- NGO Mental Health Lived Experience Workforce Standards and Guidelines Self-Assessment Tool: **mhcsa.org.au/toolkit**

Workplace culture

Emerging best practice strategies and outcomes

Emerging best practice strategies for workplace culture	Outcomes/benefits of strategies	Issues and risks if not addressed
Preparation and planning before and after employing lived experience workers, including the value of roles by executive management, carried through and championed at all levels of the organisation	Lived experience workers are better understood and valued within teams	Lack of preparation, planning or priority given to the development and 'launching' of lived experience, leads to roles being poorly accepted or embedded within the organisation
Organisation encourages openness to hearing different perspectives, including ongoing opportunities for open discussions/forums with whole-of-organisation	Openness to change allows person-directed and recovery-orientated practice to develop further	Feelings of marginalisation or 'othering' for lived experience
Ongoing exposure/training about lived experience principles, and the benefits of lived experience work for people in non-designated roles, including management and colleagues	Lived experience roles are collaborated with and used in a way that is meaningful to the organisation and people accessing the service	Stigma/prejudice may recur due to staff turn-over, lack of communication, fear or lack of understanding
Training/ongoing conversations for people in lived experience roles to similarly understand the role of colleagues	Mutual respect and collaboration Support from the existing workforce	Lower collaboration between lived experience non-lived experience roles
Active collaboration within team and opportunities for co-design and co-production	Open communication, sharing of ideas, shared priorities	Working in silos
Pro-actively support diverse cultures and sub-cultural groups including Aboriginal and Torres Strait Islander peoples, people from culturally diverse backgrounds, people identifying as LGBTQIA+ and people with disability (among others)	A level of relatability with lived experience workers who represent cohorts encourages more natural and effective relationships and better outcomes for people accessing services	Not understanding the need to have diversity and representation within the lived experience workforce, subsequently not providing culturally appropriate lived experience workforce for people accessing services
Organisation interested in the wellbeing of all employees and develops strategies collaboratively to support greater wellbeing for all, including a safe environment for all employees to disclose and gain support in the workplace	Greater work satisfaction, feelings of being valued and belonging for all employees Feeling supported and safe at work Likelihood of earlier help-seeking and decreased severity/longevity of mental health challenges	Resentment towards the lived experience workforce who are supported as being 'out' with lived experience Continuation of fear to disclose/stigma and reduced help-seeking

Diversity and inclusion

Benefits of diversity and barriers to inclusion for lived experience workers from diverse cultures and experiences

Embracing diversity within workplace culture fosters mutual respect for all employees and recognises the strengths that diversity brings. Lived experience roles work with people from diverse cultures and experiences. This requires lived experience workers to respect differences and show understanding of diverse perspectives and needs, including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people from the Deaf community, people identifying as LGBTQIA+, veterans, people identifying as neurodivergent, people with disability, children and youth, older persons, people with a history of trauma, people with experiences of family and domestic violence, perinatal mental health, eating disorders, suicide, incarceration, involuntary treatment, alcohol and other drug use or dependence, homelessness and other diverse experiences.

Emerging best practice examples

LGBTQIA+ policy

Brook RED have developed the 'Rainbow RED' policy that supports their commitment to ensuring they are an organisation that is welcoming, inclusive and responsive to LGBTQIA+ people. This policy is based on the principle that everyone deserves to be treated with dignity and respect. The policy includes a commitment to use inclusive and respectful language in all conversations and to develop, maintain and annually review a Rainbow RED Language Guide. In addition, the policy includes mandatory LGBTQIA+ and diversity training and a commitment to diversity and affirmative action in recruitment that includes statements to encourage LGBTIQA+ people to apply. This policy is based on a recognition of the importance of diversity and a belief that everyone should feel safe to be and express who they are. Brook RED also understand that LGBTIQA+ people may experience mental health and suicidal distress in ways that are intersectional with gender and sexuality and that supports need to be designed and delivered with this in mind.

LGBTQIA+ peer-led service

Bayside Initiatives Group (BIG) applied for funding to start a peer-led LGBTIQA+ service in the Redlands area. This service named 'Belong' was a response to the lack of specific LGBTQIA+ peer spaces within the community. The funding covered the cost of a BIG staff member for two hours every fortnight. The program was shaped by what participants wanted the group to look like and how it would operate. Early on, a set of general guidelines was developed by the group that essentially sought to allow for mutual respect towards all who attended. A meal was shared at each meeting and discussion was free flowing. As time went on, activities in the community were also added. BIG "Belong" program is a collaboration with Brook RED. Brook RED offer intensive one-on-one peer support as part of the program.

Diversity and inclusion

Additional resources

Aboriginal and Torres Strait Islander peoples resources

- Indigenous Lived Experience Project Report: **blackdoginstitute.org.au/docs/default-source/lifespan/lived-experience-report--final-nov-2018.pdf?sfvrsn=2**
- Gidgee healing Aboriginal Community Controlled Health Service—a commitment to providing holistic and culturally appropriate health services: **gidgeehealing.com**
- Deadly Thinking: a social, emotional wellbeing and suicide prevention program for Aboriginal and Torres Strait Islander communities: **rrmh.com.au/programs/deadly-thinking**
- Link-up (Qld): for individuals, families or communities who have been affected by past Australian government removal policies and practices, including separation through adoption, fostering, removal or institutionalisation: **link-upqld.org.au**
- The Glen Aboriginal Drug and alcohol rehabilitation centre: **theglencentre.org.au**

Multicultural/Transcultural resources

- Framework for Mental Health in Multicultural Australia: Towards culturally inclusive service delivery: **https://mhima.org.au/service-providers/framework-landing**
- Queensland Transcultural Mental Health Centre: **http://peerworkhub.com.au/wp-content/uploads/2016/05/2-define-purpose.pdf**
- Embrace multicultural mental health: **https://embracementalhealth.org.au**

Resources related to people with experiences of alcohol and other drug use or dependency

- QuIHN: Queensland alcohol and other drugs service that offers information and peer support: **quihn.org**
- SHARC Peer Worker Training for existing and emerging peer workers seeking foundational peer worker training, also providing specialisations in Alcohol and other Drugs: **sharc.org.au/peer-support**

LGBTQIA+ resources

- LGBTQIA+ peer support and referral service: **http:/qlife.org.au**
- 'Australian Workplace Equality Index' is the national benchmark on LGBTQIA+ workplace inclusion: **pid-awei.com.au**
- The National LGBTI Health Alliance is the national peak health organisation in Australia for organisations and individuals: **https://lgbtihealth.org.au/about**

Resources related to the Deaf community

- Deafness and Mental Health Resources and Guidelines: **https://metrosouth.health.qld.gov.au/mental-health/services/deafness-and-mental-health**

Resources related to people with disability

- People with Disability Australia (PWDA) is a national disability rights, advocacy and representative organisation that is made up of, led and governed by people with disability: **https://pwd.org.au**
- Australian Network on Disability—Inclusive Language: **and.org.au/pages/inclusive-language.html**
- Diversity Council of Australia—Inclusive Language: **dca.org.au/inclusive-language-0**

Resources related to young people and perinatal mental health

- Batyr: Created by and for Young People: **batyr.com.au**
- Peachtree Perinatal Wellbeing: **https://peachtree.org.au**

Diversity and inclusion

Emerging best practice strategies and outcomes

Emerging best practice strategies for diversity and inclusion	Outcomes/benefits of strategies	Issues and risks if not addressed
Preparation, education and communication with the existing workforce prior to commencement of roles, to ensure a smooth entry to the workforce for people from diverse cultural backgrounds including Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds	Higher retention of staff from culturally diverse backgrounds Support at all levels of the organisation to be a culturally safe and respectful environment for staff and people accessing services Furthering the efforts of reconciliation by providing educational opportunities and support within the workplace	Lack of cultural safety and support for Aboriginal and Torres Strait Islander peoples and people from culturally and linguistically diverse backgrounds Reduced benefits/positive outcomes for people accessing services who come from diverse cultural backgrounds
Making reasonable adjustment of work premises, schedules and equipment, and providing training, as required, to enable accessibility and preparedness for lived experience workers with disability and people from the Deaf community	Lived experience workers who represent people with disability and the Deaf community accessing services	Less effective lived experience workforce for people with disability and the Deaf community accessing services, exclusion of lived experience with disability and Deaf people from the workforce
Targeted strategies such as using bilingual workers and assertive outreach to culturally and linguistically diverse networks Culturally targeted approaches to overcome barriers such as stigma, low levels of mental health literacy, lack of diverse explanatory models of 'illness' and language barriers are required Recruiting proactively for workers from Aboriginal and Torres Strait Islander and other marginalised groups	Culturally inclusive lived experience workforce practices Inclusion and better retention of diverse lived experience perspectives/roles	Traditional mechanisms such as advisory groups, participation in networks and partnerships are not likely to engage people from culturally and linguistically diverse backgrounds and may perpetuate further social exclusion
Recognising preferred cultural understandings and practices as part of healing for Aboriginal and Torres Strait Islander peoples, including use of language and cultural meaning. Social and emotional wellbeing is generally preferred rather than 'mental health' to describe the holistic wellbeing of Aboriginal and Torres Strait Islander communities	Inclusive cultural practice that includes the important role of connection to land, community, family and spirituality Traditional practices are given appropriate place alongside Western medical treatment and perspectives	Insensitive and exclusionary practice that is not safe or welcoming for Aboriginal and Torres Strait Islander communities Risk of not respecting the unique identity and strength of Aboriginal and Torres Strait Islander peoples

Diversity and inclusion

Emerging best practice strategies for diversity and inclusion	Outcomes/benefits of strategies	Issues and risks if not addressed
Create and publicise LGBTQIA+ friendly policies. Having LGBTQIA+ allies in the workplace, mentoring and support groups within and beyond the organisation	Inclusive and non-discriminatory workplace for LGBTQIA+ employees to feel comfortable to disclose	Excluding people who identify as LGBTQIA+ impacting feelings of comfort/safety for people accessing services
Acknowledging significant cultural holidays and celebrations will enable the workforce to not feel guilt or pressure in requesting time to attend such events. Where appropriate and agreed, support attendance at these events to show organisational commitment to cultural practices and further promote an inclusive workplace	Less anxiety amongst the workforce in requesting time to attend something of cultural significance and importance Reduction in unplanned leave when employees take time off if not allowed	Conflict between work and cultural, religious and spiritual practices, holidays and celebrations Community perceptions of organisational support for Aboriginal and Torres Strait Islander and other cultures is decreased
Acknowledge cultural values and staff commitment to responding swiftly to family and community responsibilities. Where appropriate, support the employee and community by all means necessary	Demonstrate cultural understanding and gain respect and support within the community Likelihood of longer retention of community members with a flexible approach	Conflict between family and community obligations versus organisational deliveries and expectations

Human resources policy and practices

Policy and practice are tangible outcomes of commitment by organisations and formalise work culture. The role of human resources policy and organisational process that align with lived experience concepts is increasingly understood as critical for effective lived experience work and employment.

At organisations with a strong commitment to lived experience work, this includes human resources having an understanding of lived experience concepts, including their uniqueness and value to assist in creating policies that understand and are appropriate/adaptable to lived experience work.

At lived experience-run organisations, it is common for people in all roles to have a lived experience and to draw from that understanding/experience in their role. This includes people employed in human resources positions. The potential for lived experience involvement and/or designated lived experience roles in human resources departments may be significant not only in the development and support of people in lived experience roles, but in shaping work practices and policies that can benefit anyone in the workplace who has a lived experience.

Additional resources

- *Mental Health Peer Workforce Development Plan Gold Coast 2015–20* developed by the Peer Workforce Reference Group and sponsored by Gold Coast Partners in Recovery: **healthygc.com.au/MedicareLocal/media/Site-Pages-Content/Mental%20Health/Mental-Health-Peer-Workforce-Development-Plan-2015-2020-ALL-DOCUMENTS_1.pdf**
- Universal Declaration of Human Rights: **un.org/en/udhrbook/pdf/udhr_booklet_en_web.pdf**

Human resources policy and practices

Emerging best practice examples

Credentialing policy

Brook RED have developed a credentialing policy that outlines Brook RED's commitment to education for its employees. This policy is based on the belief that when lived experience workers hold at least minimum-level qualifications to support their practice, this increases the credibility of the lived experience workforce, and supports upward employment and educational mobility. This policy also acknowledges that many lived experience workers may not have had the opportunity to gain formal qualifications and by including this in policy, Brook RED is committed to supporting this process for its employees. Where an employee does not possess the Certificate IV in Peer Work qualification on commencing employment, Brook RED will support the employee to gain this qualification and will pay registration and tuition costs as well as providing negotiated paid time for study.

Lived experience leadership roles/purposeful, lived experience-led recruitment strategies

Metro South Hospital and Health Service Addictions and Mental Health Services have committed to lived experience on a strategic level through creating lived experience leadership roles. Lived experience leadership is evident in the creation of a Lived Experience Director position that is part of the executive team and Metro South Addiction and Mental Health Services have created a workforce pathway for all peer workers. In five years, Metro South Addiction and Mental Health Services have increased the lived experience workforce 10-fold and the service recognises the benefits of this workforce. They have two peer supervisor positions and the workforce receive operational and professional supervision by a lived experience worker. This growth has been aided by the development of clear position descriptions, and having peer workers involved in selection and recruitment, research and reviewing all documents within the service. The lived experience workforce is recognised as a unique discipline and flexibility is provided as required.

Reasonable adjustments whole-of-workforce education

A highly experienced consumer consultant with the Darling Downs Hospital and Health Service gave presentations and provided information on reasonable adjustments to every team within the mental health service. This included information on legislation and policy related to reasonable adjustments and how they may impact people in lived experience roles as well as anyone who has lived experience. Information covered the need for people to feel comfortable to ask for reasonable adjustments to maintain their employment. There was an overwhelming response from case managers who reported back to say what a difference knowing this had made. An understanding of reasonable adjustments also supported workplaces in becoming more flexible, understanding and compassionate of all people with a lived experience whether their role was designated lived experience or not.

Human resources policy and practices

Emerging best practice strategies and outcomes

Emerging best practice strategies for human resources policy	Outcomes/benefits of strategies	Issues and risks if not addressed
Human resources is committed to and understands Lived experience roles and is willing to work with available funding in creative ways. May include having designated lived experience roles working with or consulting with human resources	Using available funds in ways that protect authenticity of lived experience roles and promote best outcomes	A lack of designated funding limits employment of lived experience and sustainability of programs
Lived experience recognised as a distinct discipline/way of viewing and working. Lived experience specific policies are developed with lived experience guidance including policies related to people accessing services i.e. medication monitoring, writing of progress notes or any form of restrictive or coercive practice	Lived experience workers are perceived as credible and valued and enabled to work from their unique perspective	Lived experience workers lack confidence in their own roles and knowledge base Lived experience workers undergoing unnecessary training and practicing in ways that do not align with lived experience values or concepts
Clear job descriptions informed by lived experience concepts and leaders	Role clarity/increased understanding of lived experience roles for all workers	Lived experience work can be compromised by more dominant practice
Recruitment to 'senior' lived experience roles (including team leader and management positions at any level) requires prior experience in lived experience work and/or strong, demonstrable understanding and connection to wider lived experience movement/concepts. An individual lived experience without deep understanding of lived experience work/concepts is not sufficient	Appropriate people for the job who have the skills and knowledge specific to lived experience roles. Can assist in providing role clarity to other lived experience and helping guide further development of the lived experience workforce	People with management or other relevant experience but without the essential knowledge and context of lived experience work are employed. Unique features/skills/benefits of the roles are undermined or not developed, role clarity/lived experience supervision for other lived experience workers is not provided
Access to lived experience professional supervision is provided. This may be internally provided within the organisation or external	Ongoing and responsive role clarity, growing confidence for LE roles in their own unique knowledge and skills	Erosion of role clarity and/or diminished confidence for lived experience roles

Human resources policy and practices

Emerging best practice strategies for human resources policy	Outcomes/benefits of strategies	Issues and risks if not addressed
Whole-of-workplace approach and flexibility includes an acknowledgment of the ups and downs in any person's life and the need for self-care	Greater retention of all employees and increased job satisfaction. Greater benefits to people with a lived experience who do not work in designated lived experience roles. Managing expectations and concerns of existing workforce regarding inequity of access to flexibility	Burn out/absenteeism, recurring periods of unwellness Negative perceptions of lived experience workers getting 'special treatment' and being fragile or unprofessional. Colleagues choose not to collaborate with lived experience workers
Appropriate recruitment processes including adequate remuneration and FTE for lived experience	Improved morale, sense of being valued/belonging, improved credibility/value to others in the workplace, increased job performance	Unequal pay, FTE that are insubstantial/ inappropriate to the work may mean people need to take multiple jobs, impacting morale and job performance
Reasonable adjustments are openly acknowledged as part of the legal rights of all employees who experience impacts of disability including mental health. Reasonable adjustments are easily accessible	All employees are aware of legislation and their rights. Employees experiencing any disability can work safely and maximise their potential	Workers may be working under conditions that are damaging to their mental health or in a way that reduces their productivity

Professional development and training

Key to developing and sustaining a robust lived experience workforce are opportunities to develop, define, refine, and clarify the knowledge and skills needed to be effective in lived experience roles.

Whether for entry-level positions or executive management roles, supervision, training, networking and education opportunities allow individuals and organisations to achieve and maintain best practice. However, training for people in lived experience roles can be hard to access or not available, particularly in regional, rural and remote areas. Similarly, a lack of lived experience networks, conferences and professional development (PD) funds in addition to a 'time-poor' workforce limits opportunities to network, share and disseminate knowledge.

Whole-of-organisational training is essential to increase understanding of lived experience work and encourage genuine collaboration, as well as enlisting management support and commitment. Training that makes explicit the connection between personal recovery, person-directed service delivery and lived experience work is particularly useful. Training is most beneficial when it is ongoing and revisited, rather than a one-off. Importantly, training that is specifically for people in lived experience roles or to explain lived experience roles to others in the workplace must be lived experience-led and delivered to ensure fidelity with lived experience concepts.

Additional resources

- Intentional Peer Support Training. Contact IPS Australia: **au@intentionalpeersupport.org** For more information about Intentional Peer Support: **sharc.org.au/peer-support/intentional-peer-support/**
- Certificate IV in Peer Work. An overview of the course and link to providers is available at: **myskills.gov.au/courses/details?Code=CHC43515**
- Links to available training opportunities including the Certificate IV in Peer Work and Wellness and Recovery Action Planning: **mymentalhealth.org.au/page/consumer-and-carer/lived-experience/peer-related-training-opportunities/**

Professional development and training

Emerging best practice examples

Lived Experience Network, Brisbane North

The Brisbane North Peer Participation in Mental Health Services (PPIMS) Network is a group of People with Lived Experience (PLE) in Brisbane North. The purpose of the network is to work collaboratively to actively participate in mental health systems and reforms. PPIMS aims are to have a collective voice, support other PLE to get involved, have regular updates, and recommend strategies to improve PLE engagement, provide advice on emerging issues and participate in co-design opportunities. Membership includes a range of PLE who live in the region (e.g. peer workers, other general mental health workers who are also PLE volunteers, PLE trainers, educators, students and academics, consumer and carer representatives. PPIMS has actively contributed to providing submissions to regional, state and national bodies seeking PLE engagement.

Community of practice

Brisbane South Primary Health Network Lived Experience Workforce Community of Practice (empowering peers to thrive) is a pilot project in Brisbane South. The goal of the project is to support the existing workforce and build capacity of emerging lived experience leaders. The community of practice is co-designed with people with lived experience who are engaged with organisations either in a voluntary or paid capacity to encourage collaboration within the Brisbane south region.

Lived experience accreditation

The Sunshine Coast TAFE offering of the Certificate IV in Mental Health Peer Work maintained the philosophy of the lived experience approach including the essential role as ‘change agent’. This offering addressed the challenges inherent in lived experience work within mainstream service delivery. Lived experience participants learned to work with their lived experience in a consistent manner that responds to industry standards and needs in a work ready manner, while holding onto the validity and power of the strengths-based approach of lived experience. Lived experience practitioners learned not to be subsumed by the dominant paradigm of ‘medicalising life interruptions’ and maintaining a vision past the concepts of deficit and pathology.

Professional development and training

Emerging best practice strategies and outcomes

Emerging best practice strategies for professional development and training	Outcomes/benefits of strategies	Issues and risks if not addressed
A range of timely supervision offered including: • lived experience-led • ad hoc and formal • internal and external • co-supervision, group supervision	A well-supported lived experience workforce that is reflective and purposeful in their use of lived experience Ongoing opportunities to address role clarity and debrief	Limited opportunities for supervision and/or no option for lived experience specific supervision limits role clarity and can contribute to confusion around the role. Limited opportunities to debrief contributes to a poorly supported lived experience workforce
Lived experience leadership roles, including management, team leaders and senior peer roles and lived experience in supervisory roles	A higher skilled workforce. A workforce that is purposeful and has greater autonomy Retain experienced and skilled lived experience employees Opportunities for career mobility/ advancement Lived experience leadership and greater capacity for change 'In-house' lived experience-led supervision and training development	Lack of career progression, loss of experienced and skilled lived experience workers to better paid/ senior positions in other industries/ roles Senior positions need to be substantial enough to attract suitable people
Training for colleagues and management on lived experience concepts and functions	Mutual understanding, respect and higher willingness/ability to collaborate effectively	Poor understanding and acceptance, reduced willingness/ability to collaborate
Provision of lived experience traineeships as a form of on-the-job training	New lived experience workers can learn from experienced lived experience. Provides coaching/role clarity, self-confidence	Lack of widespread training can mean lived experience start roles with no training and lower self-confidence and clarity on role
Lived experience-led training specifically focusing on use of lived experience and unique knowledge	A more reflective and confident workforce that understands how to use their lived experience meaningfully and appropriately	Incomplete understanding and confidence in applying personal experience and turning experience into 'expertise'
Funded positions in the Certificate IV in Mental Health Peer Work for entry/ introduction to the mental health service sector	An ethical lived experience workforce that understands how to work with risk and respond in ways that promote safety for all workers	Limited understanding/ orientation to the service system and standard processes

Professional development and training

Emerging best practice strategies for professional development and training	Outcomes/benefits of strategies	Issues and risks if not addressed
Research higher degrees with a focus on lived experience concepts or work to develop evidence base and inform evidenced-based practice	Lived experience co-production of what counts as evidence and informs service and systems change	Poor representation of lived experience perspectives in research limits movement towards systems transformation and national reform agenda
Membership of communities of practice and other relevant networks that provide access to other lived experience workers, particularly for organisations and workers in rural and regional areas	Cross-fertilisation of ideas, collaboration across services/sector, opportunities for mutual support	Lack of collegiality and sense of isolation, particularly when part of a small lived experience workforce
Ensure professional development funds allow lived experience access to conferences including local, state and national opportunities	Access to opportunities to share and disseminate knowledge, learn about and apply best practice, resources and contemporary evidence	Limited or no access to best practice and emerging practices to inform ongoing development

Ongoing development

In the literature, ongoing development is mentioned frequently, particularly in similar strategy and framework documents from other states. This corresponds with responses from the Framework Advisory Group stating that while much has been learned and achieved, as a workforce that is still emerging, there are areas of great importance that require consideration for ongoing, sustainable workforce development. Similarly, research findings strongly indicate development of the lived experience workforce requires further actions to allow the work to be embedded meaningfully in the wider mental health sector. Areas of ongoing development that are deemed particularly important to current and emerging practice are highlighted.

Emerging best practice examples

Independent professional network/community of practice

Mountains of Hope Peer Network (MoHPN) in Toowoomba is a not-for-profit community-managed peer network. MoHPN maintains a register of suitably trained and experienced peer specialists who are available to deliver training, facilitate workshops and contribute consumer and carer perspectives to organisations. MoHPN provides members with an opportunity to be part of a network of mental health peer support workers who receive ongoing mentoring, supervision, professional development, education and training to ensure the integrity of best practice. MoHPN works towards increasing the understanding and value of mental health peer support in the broader circles of the community, e.g. presentations to universities, mental health services, GPs, emergency departments, PHNs and police. Some of the achievements of the MoHPN to date include: 32 peers trained in the Certificate IV in Peer Work and 14 people have gained employment. MoHPN has also become the go-to organisation in the area for work places that wish to recruit peer workers who can hit the ground running, having received training and will continue to receive ongoing mentoring, supervision and support.

Lived experience-staffed emergency department alternative

Brook RED and Enlightened Consultants have collaborated to design and deliver 'The Living EDge', at Redland Hospital. The Living EDge is a peer-hosted space that serves as an alternative and adjunct to the emergency department (ED) and has specifically been designed for individuals experiencing suicidal distress. This initiative, funded by Queensland Health Suicide Prevention Health Taskforce network, has been co-designed with the community, people who access mental health services, families and clinicians and supported by Metro South Addiction and Mental Health Service. This project demonstrates commitment and collaboration in developing innovative, alternative peer approaches to meet the gaps in service delivery. The project is also supported by a community-based peer team and offers weekly group support and access to individually tailored activities such as running groups, art classes, yoga and other activities.

Lived experience advocate at Energy Queensland

Energy Queensland (Energex/Ergon) created two lived experience mental health advocate roles. This role is unique and in the first 12 months earned the organisation a top three place in the Australian Human Resource Institute workplace mental health awards last year. These roles advocated for a different approach to mental health within the energy industry and includes delivery of the pilot program of 'Mates in Energy' born from 'Mates in Construction', aimed at suicide prevention in the energy industry. The roles provide on-the-ground lived experience support for employees and broader level stigma reduction and awareness raising by sharing lived experience and promoting help seeking and conversations around mental health challenges. They have also worked on the development of the Energy Queensland Mental Health Strategy for the next four years and are able to influence at senior executive/CEO decisions in the business to ensure employee wellbeing is at the forefront of those decisions.

Ongoing development

Emerging best practice strategies and outcomes

Emerging best practice strategies for ongoing development	Outcomes/benefits of strategies	Issues and risks if not addressed
Organisations and funding bodies		
Senior lived experience roles in all key mental health or mental health related organisations including funding bodies and/or boards and tenders	Greater accountability in working towards identified and agreed reform efforts including, meaningful co-production with people with a lived experience	Lived experience not a priority, overlooked in planning, funding or budgets Lived experience perspectives not embedded in critical policy documents and strategies
Lived experience across all levels of the organisation, on every committee, recruitment panels and as part of inducting all new staff	Ensures lived experience always has a voice at the table/remains on the agenda and lived experience perspectives are embedded Contributes to career pathway within lived experience workforce so lived experience do not have to move to non-lived experience roles to progress career	Lived experience workforce development limited. 'Brain drain' as highly skilled and experienced lived experience leave organisations/ lived experience roles to pursue career progression
Training/exposure to lived experience concepts/work/movement for all key agencies and funding bodies	Greater understanding and higher perceived value attributed to LE, leading to greater priority in budgets, planning and funding	Service design and funding doesn't understand the unique contribution of lived experience roles, lived experience roles can be co-opted
Develop ongoing mentoring and formal networks to allow resource sharing and assistance between organisations with a priority on lived experience employment	Increased understanding, motivation/ action/peer learning between organisations to ensure lived experience roles are meaningfully designed, supported and embedded	How to effectively design and support roles is not understood, lived experience roles are less effective, the unique benefits are reduced or lost
Credentialing policies for organisations and funders to provide opportunities for scholarships/paid accreditation as part of roles	Provide entry level qualification, so lived experience employees are supported to have an ongoing career beyond the organisation/situation they're currently in	Certificate IV in Mental Health Peer Work is expensive and difficult for many lived experience workers to attain without support from funders/ employers. This can limit access to lived experience roles

Ongoing development

Emerging best practice strategies for ongoing development	Outcomes/benefits of strategies	Issues and risks if not addressed
Funding		
Greater access to designated lived experience funding that understands and responds to the uniqueness of the roles, including lived experience-led initiatives, services and organisations	Opportunity to create sustainable alternatives to traditional service pathways and explore full potential of lived experience work	Lack of designated funding, limits sustainability and development of the workforce
All commissioning or tendering includes lived experience representatives. Have KPIs in contracts to ensure adequate lived experience involvement	Lived experience priorities and unique work outcomes considered in funding design. Accountability built in to contracts to ensure lived experience perspectives are meaningfully represented	Funding not being renewed and/or changes to funding due to political shifts and lack of priority, visibility of lived experience (rather than lack of demonstrable outcomes of lived experience work)
Lived experience is valued in all roles		
Lived experience is identified as desirable and valued within all roles, not just in designated roles	Non-lived experience learning from lived experience about how to use lived experience effectively and how and when to share experiences Non-lived experience workers with lived experience feeling accepted and valued, contributing to a culture of safe disclosure	Inappropriate or 'hidden' sharing of lived experience Workplace where there is a lack of transparency and openness and less acceptance for people with a lived experience impacting non-lived experience colleagues, lived experience workers and people accessing services
Advocacy and human resources development		
Development of an effective and adequately resourced independent lived experience peak body and union Development of industrial relations awards and conditions including a specific award wage for lived experience roles Peak body to act as liaison or connector between organisations, training developers and funders—what's needed, how much and advocating for resources	Supervisors of lived experience workers are more confident and able to appropriately support lived experience roles, particularly in maintaining role clarity Authenticity of lived experience perspectives and unique ways of working are maintained and valued. Lived experience workforce are supported to be effective and given opportunities for professional development	Poor quality of supervision for lived experience roles and impeded confidence/job satisfaction for supervisors and lived experience workers Lived experience workers are required to have supervision with a supervisor from outside their discipline. Lived experience workforce perceived as valued less than other perspectives (which receive discipline-specific supervision)

Ongoing development

Emerging best practice strategies for ongoing development	Outcomes/benefits of strategies	Issues and risks if not addressed
Supervision		
Training and specific supervision for supervisors of lived experience workers is needed to assist understanding of lived experience roles	Supervisors of lived experience workers are more confident and able to appropriately support lived experience roles, particularly in maintaining role clarity	Poor quality of supervision for lived experience roles and impeded confidence/job satisfaction for supervisors and lived experience workers
More lived experience supervision is needed. Investment in upskilling the existing lived experience workforce is needed to expand opportunities for lived experience supervision. Support lived experience workers to access external lived experience supervision. Establish a register of external lived experience supervisors	Authenticity of lived experience perspectives and unique ways of working are maintained and valued. Lived experience workforce are supported to be effective and given opportunities for professional development	Lived experience workers are required to have supervision with a supervisor from outside their discipline. Lived experience workforce perceived as valued less than other perspectives (which receive discipline-specific supervision)
Training		
Additional qualifications are needed at various points of career progression including high-level qualifications but also affordable and accessible entry level credentialing (i.e. Certificate IV in Mental Health Peer Work)	Increased credibility of lived experience work, particularly for management and other senior roles. Better articulation of the value of roles across career progression and better, more specific training	Lack of specific training and less relevant materials/delivery across the career span limits the development of lived experience roles in various contexts and impedes credibility of the roles
As the only nationally recognised accreditation, the Certificate IV in Mental Health Peer Work needs greater accountability for quality of materials and who is delivering it (needs to be lived experience trainers)	More effective and respected accreditation and other specific training, with highly relevant delivery and materials assists in role clarity for workers and better outcomes for organisations overall in employing lived experience workers	Impacted ability to gauge and maintain role clarity at various points across career span places limits on the confidence and potential performance of lived experience workers
More lived experience role specific training focusing on the unique features and definitions of lived experience roles is needed. Must be lived experience-led and delivered		

Ongoing development

Emerging best practice strategies for ongoing development	Outcomes/benefits of strategies	Issues and risks if not addressed
Higher education and research		
Increased lived experience leadership/ co-production of research and dedicated funding for lived experience research TAFE and universities create targeted positions for lived experience researchers, teachers, lecturers and engagement officers	Opportunities to explore the needs/ benefits of lived experience and add to the evidence base Alignment with national policy in relation to 'service user involvement' e.g. National Health and Medical Research Centre's national statement	Lived experience perspectives in research and higher education limited and often tokenistic. If the education and evidence provided to mental health professionals does not include lived experience as a valued and valuable contribution, workforce acceptance of lived experience will remain limited
Regional, rural and remote		
Prioritise development of lived experience roles in rural and regional areas including provision of 'train the trainer' workshops to allow community members to be trained within their community in an ongoing, accessible way. Training to include how to incorporate cultural practices and benefits within the service 'Exchange programs' to bring exposure to lived experience work to regional, rural and remote areas Communities of practice and key meetings/networking opportunities to include video link-up for regional/ rural and remote participation Specific exploration of the needs of people in regional, rural and remote areas in relation to lived experience development	Access to lived experience work allows people accessing services a range of services/service relationships to assist in finding the best 'fit' for their personal recovery journey. The ability to train within the community ensures skills aren't lost if people move away and emphasises local knowledge Increase profile and understanding/ priority on lived experience roles in regional, rural and remote areas Increase access to support, education and emerging best practice for regional/rural and remote organisations and lived experience Ensure the unique needs and issues faced by people and lived experience in regional, rural and remote areas are addressed	Lived experience is highly relevant for rural and regional areas but largely unavailable. Overall, a lack of health professionals and services creates lack of choice for people in rural and regional areas. Similarly, tyranny of distance creates difficulty accessing services, adding to the cost of service use Limited access to lived experience roles progressively north of the Sunshine Coast and particularly in the western parts of the state Lived experience roles that do exist in rural and remote areas are isolated and miss out on networking, support, education and development Ongoing under-representation of lived experience roles in regional, rural and remote communities and limited understanding of the needs of communities in relation to lived experience work

Ongoing development

Emerging best practice strategies for ongoing development	Outcomes/benefits of strategies	Issues and risks if not addressed
Diversity and inclusion		
Explore concepts and language of lived experience work/mental health from the perspectives of Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse backgrounds to ensure Westernised definition and practices aren't exclusively enforced Create pro-active policies to ensure cultural diversity within the lived experience workforce	Higher numbers of culturally appropriate, diverse and 'safe' lived experience workers to better meet the needs of people from diverse cultural backgrounds and assist in best practice outcomes	Perpetuating poor engagement and participation of diverse cultural groups in the lived experience workforce, leading to less relevant lived experience workforce for people accessing services who come from diverse cultural backgrounds Ongoing under-representation of culturally diverse roles and subsequent lack of access to culturally specific lived experience for people accessing services
lived experience roles beyond mental health		
Designated lived experience roles within sectors other than mental health	Greater understanding and acceptance of people with a lived experience throughout industries, leading to improvements to work cultures Greater job opportunities for people in non-lived experience roles with lived experience, higher retention of people with a lived experience across the workforce, more supported return to work for people with a lived experience	Continuation of stigmatising and prejudicial attitudes towards people with a lived experience Reluctance for people to disclose mental health challenges and seek help in the workplace Continued limits on sustainable employment for people with mental health challenges

Key areas and supportive factors

Queensland Framework for the Development of the Mental Health Lived Experience Workforce

Ongoing development

- Develop lived experience leadership roles in all relevant organisations
- Encourage greater access to designated lived experience funding and better representation of lived experience on funding bodies
- Encourage an adequately resourced and independent lived experience peak body
- Explore culturally appropriate lived experience language and concepts
- Develop and invest in lived experience roles (including training opportunities) in rural and regional areas

Understanding and defining lived experience roles

- Exposure to lived experience concepts, research, leaders & work
- Develop a network of organisations building a lived experience workforce
- Provide clear position descriptions
- Acknowledge unique cultural differences and the value of specialisations

Organisational commitment

- Management actively champions lived experience roles to ensure uniqueness is protected
- Employ sufficient numbers of designated lived experience workers, including management roles
- Create a culture of learning, innovation and self-reflection
- Create processes and systems to support lived experience roles

Professional development and training

- Source appropriate training and education e.g. Certificate IV, Intentional Peer Support, research degrees
- Provide lived experience networks and communities of practice
- Allocate lived experience professional development funds/conferences
- Ensure a range of timely supervision (including lived experience supervision) is available
- Ensure lived experience traineeships are available

Workplace culture

- Prepare and plan before and after employing lived experience workers, including promotion of the value of roles at all levels of the organisation
- Provide ongoing exposure/training for all staff (including at induction) about lived experience principles, work and benefits
- Commit to the wellbeing of all staff, developing strategies and policies to support better wellbeing

Human resources policies and practices

- Ensure human resources teams understand and are supportive of lived experience roles
- Recognise lived experience as a distinct discipline and approach
- Provide appropriate recruitment processes with adequate remuneration and FTE for lived experience
- Ensure a whole-of-workforce approach to reasonable adjustment and flexibility

Diversity and inclusion

- Proactively support diverse cultures and subgroups
- Publicise policies that facilitate inclusive culture
- Use targeted strategies to overcome specific barriers to inclusion for diverse cultural groups
- Acknowledge cultural values and staff commitment to community and cultural holidays

To view the full framework and support resources, scan this QR code or download from the Queensland Mental Health Commission's website: qmhc.qld.gov.au/engage-enable/lived-experience-led-reform/peer-workforce

Queensland **Mental Health Commission**

Appendix

Key themes from literature mapping

Themes		Context
Role clarity	• Recruitment and orientation • Clarity of differences between specific lived experience roles, as well as between lived experience and non-lived experience roles	• Position descriptions reviewed with lived experience input • Sensitivities to Aboriginal and Torres Strait Islander peoples and LGBTQIA+ lived experience workforce • Clear service models
Design of roles	• Lived experience workforce roles are: – recovery-oriented and strengths-based – trauma-informed and person-centred – holistic and culturally inclusive – equal and empathetic	• Lived experience workforce-specific remuneration awards, which are appropriate and comparable to non-lived experience • Lived experience workforce involved in role design • Diversity across roles recognised
Development of lived experience management roles	• More lived experience workforce in senior, decision-making roles will enhance the sector's ability to design and deliver better services	• Foster mentoring, development and career progression pathways for lived experience • Structured career pathways required
Organisational support, commitment and workplace culture	• Initiatives to increase lived experience workforce (e.g. commissioning processes) • Lived experience workforce involved in planning and implementation of lived experience roles and relevant policies and procedures • Commitment to lived experience workforce articulated in governance, strategy, policies and procedures • Managers understand lived experience, are commitment to lived experience and act as champions of the lived experience workforce	• Leaders are transparent and committed to strategic collaboration, sharing power and formal change management processes • Lived experience workforce has relevant resources and tools • Lived experience workforce have informal and formal support opportunities
Advocacy and recognition of lived experience roles	• Lived experience representatives on local/national committees • Creating champions of lived experience workforce • Commitment to capture and share lived experience workforce impact • Promote lived experience workforce as essential (not an add-on)	• Commitment to lived experience workforce and lived experience frameworks • Aboriginal and Torres Strait Islander peoples lived experience workforce are valued
Shared understanding and knowledge of lived experience roles	• Clear orientation training on lived experience workforce for all staff • All staff to have understanding on lived experience workforce contribution to organisational aims • Ongoing communication on lived experience workforce	• Lived experience workforce introduced to mental health community • Lived experience workforce programs are advertised • Historical and contemporary experiences of Aboriginal and Torres trait Islander peoples acknowledged

Appendix

Key themes from literature mapping

Themes		Context
Relationship between lived experience and mental health	• Collaborative and equal partnerships • Lived experience workforce role clarification needed	• Opportunities for integration
Education and training	• Lived experience-led programs and training for staff • Need for ongoing comprehensive and standardised training to be available	• Broad training for lived experience workforce • On-the-job training, formal traineeships and nationally recognised qualifications
Supervisory support	• Monitoring authenticity of the roles • Supervisors have lived experience	• Accessibility • Open, ongoing, growth-oriented
Human resources Policy	• Zero tolerance of discrimination or stigma • Diversification of lived experience workforce roles • Flexibility including reasonable adjustments • Safeguards and training in place to ensure lived experience workforce workplace health and safety (e.g. confidentiality, self-care)	• Documents are co-designed and co-produced and regularly audited • Human resources policy does not exclude people based on traditional exclusions
Barriers and limitations to implementation of lived experience	• Funding and evaluation • Role confusions, definitions • Disclosure and confidentiality • Supervision access • Medicalised mental health system • Occupational regulation and representation • No career progression	• Over-extended/burn out/isolated • Inflexible jobs • Disruption during lived experience workforce introduction • Lack of Aboriginal and Torres Strait Islander peoples lived experience • Lack of monitoring and evaluation mechanisms • Misconceptions of lived experience workforce work
Ongoing development	• Support research initiatives/evidence-based learning • Increases in lived experience workforce, LGBTQIA+ and Indigenous lived experience workforce	• Accreditation standards • Funding and scholarships • Lived experience framework for each state