

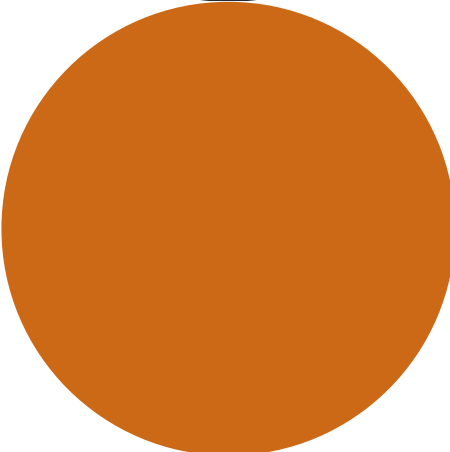


Government of **Western Australia**  
Mental Health Commission

The Western Australian

# Lived Experience (Peer) Workforces Framework

—  
For the mental health, alcohol and other drug,  
suicide prevention systems





**“Our challenge is to be bold and brave and daring enough to remain human-hearted while working in human services.”**

– Pat Deegan





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John Walley – *Walbrininy*, 2018

John Walley, a descendant of the Whadjuk clan within Noongar Country, is a Perth based artist who works mainly with acrylic and experiments with earthy materials. The MHC commissioned John to create a bespoke artwork for its

2018 – 2021 Conciliation Action Plan. The name of the artwork *Walbrininy*, means spiritual healing. The full artwork can be seen on page 2 of the MHC Conciliation Action Plan on the MHC webpage: [www.mhc.wa.gov.au/cap](http://www.mhc.wa.gov.au/cap)

## Acknowledgement and commitment to Aboriginal and Torres Strait Islander Peoples, perspectives and priorities

Australia's First Nations Peoples represent two distinct cultures, Aboriginal, and Torres Strait Islander Peoples. Within these broad cultural groups, there is also great diversity of cultures, languages, kinship structures and ways of life. Throughout this document, the term First Nations Peoples will be used to encapsulate both Peoples.

It is critical that this Framework embraces a commitment to honouring and celebrating First Nations Peoples cultures and promotes alignment of lived experience work to First Nations Peoples perspectives and practice.

Lived experience in First Nations Peoples communities is not based solely on the diagnosis and treatment of mental health or problematic alcohol and other drug use, but instead reflects a holistic understanding of social and emotional wellbeing (SEWB). As identified in the Transforming Indigenous Mental Health and Wellbeing SEWB Fact Sheet<sup>i</sup>, the SEWB "incorporates an ecological, collectivist perspective of self that is intrinsically embedded within family, community and extended kinship and clan group networks. Connections to land, culture, and spirituality shape these networks. Mental wellbeing is an important component of SEWB but needs to be viewed as only one component of health that is inextricably linked to the social, emotional, physical, cultural, and spiritual dimensions of wellbeing." The Aboriginal Health Council of Western Australia's Service model<sup>ii</sup> states that First Nations Peoples SEWB "is also shaped by a collective history of colonisation and contemporary experiences of systemic racism and marginalisation (Referred to in Figure 8: a model of SEWB). Importantly, the concept of SEWB recognises the strength, creativity and endurance of First Nations Peoples, positioning culture and community-embeddedness as protective factors they can draw on to flourish.

It is hoped that this First Nations Peoples worldview leads to a more contemporary understanding of the current whole Lived Experience (Peer) Workforces.

For First Nations Peoples, supporting each other is a culture, something they have been doing for ages – but may not have called it 'Peer Work'.

### Acknowledgement of Country

We acknowledge Aboriginal and Torres Strait Islander peoples as the First Nations Peoples and Traditional Custodians of our State and its waters. We wish to pay our respects to Elders both past and present and extend this to all First Nations Peoples seeing this message.

### Recognition of Lived Experience

This Framework recognises the leaders of the Western Australian, National and International Lived Experience, Consumer, Family (significant others) and Carer human rights movements and their advocacy to be seen, heard, and included across all aspects of the mental health and alcohol and other drug sectors. It is their courage and determination that has paved the way for the Lived Experience (Peer) workforce today.

The term 'Lived Experience (Peer)' is used throughout this document. The capital 'LE' signifies the requirement of the workforce to bring their lived and learned expertise to the range of designated Peer roles. Displaying the word 'Peer' in brackets, acknowledges the term 'Peer' but signifies that as the workforce grows, it is moving towards the term 'Lived Experience' Workforce.



## Message from the Minister



The State Government is committed to enabling Western Australians access to high-quality, responsive and collaborative mental health care. For this to occur, our mental health, alcohol and other drug sector needs to be appropriately resourced with trained and supported staff. Therefore, I am pleased to endorse the WA Lived Experience (Peer) Workforce Framework (Framework) which will aid in growing and developing the Lived Experience (Peer) workforce to assist those people experiencing mental health, alcohol or other drugs issues. It acknowledges the value of roles centred on lived experience of mental health and/or alcohol or other drug issues (consumers, families, carers and support persons) in advocating, advising, representing and supporting their peers within services.

It is through the collective action and coordinated effort of people with a lived experience, clinicians, service providers, government agencies and non-government organisations that Western Australia can achieve effective mental health, alcohol and other drug and suicide prevention systems and services. Embedding Lived Experience (Peer) roles in the health workforce across all levels, not only in personal support, but also in education, research, advocacy, management and decision-making roles, is vital to meaningful system reform.

This Framework (and its supporting resources) progresses the WA Government's State Priority to build

and sustain a Lived Experience (Peer) workforce while responding to the specific needs of WA's population and settings. In line with the Government's commitment to the National Agreement on Closing the Gap, it also enables Government to partner with Aboriginal and Torres Strait Islander people to improve health outcomes and create new employment opportunities.

I would like to thank the many consumers, families, carers, significant others, peer workers, service providers, clinicians, peak bodies and funding agencies whose personal and professional perspectives aided the development of this Framework and its supporting resources. I would especially like to acknowledge the dedication of the members of the Steering Committee and Advisory Groups<sup>1</sup> for their commitment and enthusiasm in delivering this important piece of work.

As the State plays a role in advocating for other parts of the system, including non-government organisations and primary care, to deliver the full mix of services across the needs continuum<sup>2</sup>, I look forward to the implementation of the Framework across the mental health, alcohol and other drug and suicide prevention sectors to improve the lives of Western Australians.

**Amber-Jade Sanderson MLA**  
*Minister for Health; Mental Health*

<sup>1</sup> See Lived Experience Workforce website regarding how the Framework was developed.

<sup>2</sup> Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.





## Message from the Commissioner

The WA Lived Experience (Peer) Workforce Framework (Framework) builds on the national agenda to have strong, vital and sustainable Lived Experience (Peer) Workforces embedded across Australia. This WA Framework was developed with a broad range of stakeholders, including Lived Experience leaders from a range of Lived Experience (Peer) roles. This work also included stakeholders working in peer support roles; those who are likely to receive service from people across a range of Lived Experience (Peer) roles; service providers who are familiar with the workforces, allies, peak bodies and funding agencies.

The Framework will assist in key implementation of the Mental Health Commission's Mental Health, Alcohol and Other Drug Workforce Strategic Framework 2020-2025 and Young People's Mental Health and Alcohol and Other Drug Use: Priorities for Action 2020-2025.

Underpinned by the Lived Experience (Peer) Workforces across Western Australia, the Framework promotes the partnership that services and

organisations can experience in working alongside people with Lived Experience to bridge inequities by designing and delivering human rights based, socially just, practices.

Further, it provides a clear blueprint for building, embedding and sustaining diverse Lived Experience (Peer) Workforces across the mental health, alcohol and other drugs and suicide prevention sectors.

It is important the breadth of the Lived Experience (Peer) Workforces is fully understood and meaningfully implemented in the full continuum of mental health, suicide prevention and alcohol and other drug service delivery – from prevention and primary care, through to tertiary and hospital-based responses. The Mental Health Commission is pleased to lead the development of this Framework and, along with its partners, advocate in all parts of the system, including non-government organisations and primary care, to deliver the full mix of services to support people across their life span.

**Jennifer McGrath**  
*Mental Health Commissioner*





## Overview from the Lived Experience steering committee co-chair

– Margaret Doherty

It is with pleasure as co-chair of the WA Lived Experience (Peer) Workforce Framework Steering Committee that I offer the following brief summary. I start by orienting to some key concepts that are foundational to sustaining robust Lived Experience (Peer) Workforces in the mental health, alcohol and other drug and suicide prevention sectors.

A Lived Experience (Peer) worker is *an individual who has had a personal life-changing experience* of mental health, alcohol and other drug challenges and or suicidal crisis (including thoughts, feelings or actions) *or a family member or significant other*<sup>3</sup> who has or is caring for or about someone with these experiences or who has been bereaved by suicide. The individuals, family members and significant others who work in the Lived Experience (Peer) Workforces use a combination of their *lived experience* plus training and professional development in their practice. This work has strong links to the knowledge and skills of broader social and rights movements, which are required to develop *lived experience expertise*. This expertise is a prerequisite for a wide range of volunteer and paid designated roles.

These designated roles may be positioned at frontline (the most familiar), management, strategic and Board levels. The roles may be located in a range of settings including

research, academia, consulting, advocacy as well as direct support and can be adapted to meet local needs in regional, rural and remote areas. First Nations mentors provide culturally secure responses to First Nations communities where supporting individuals, family and community members is embedded in culture. Harm reduction services run by peers have been present in the alcohol and other drug area for many years. People from ethnoculturally linguistically diverse (ELD) and Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, Asexual plus other, Sistergirls and Brotherboys (LGBTIQA+SB) communities are more likely to seek help from services or engage with research, advocacy or engagement activities which demonstrate understanding of and competency to work with their cultures. Lived Experience (Peer) workers are often the enablers to, and leaders of, these connections and inclusive practices. They advocate for lived experience perspectives to be privileged including using non-stigmatising language and practices which are in line with key principles. These foundational principles are detailed further in this document.

This Framework and supporting resources aim to guide and maintain the development of the Lived Experience (Peer) Workforces as a discipline in their own right. It is based

on specific values and principles including a commitment to social justice and human rights. Embedding Lived Experience (Peer) Workforces is acknowledged in national and state policy, recent reviews, reports and Royal Commissions as a key enabler to having individuals, families and communities meaningfully involved in the design, delivery and evaluation of services and approaches which affect their lives. The benefits of the workforces are clearly outlined further in this document.

This Framework and supporting documents are intended to be practical and accessible for all stakeholders in the mental health, alcohol and other drug and suicide prevention sectors. While this Framework was developed for these sectors, the guiding principles and their application are considered universal and transferable across other sectors that engage Lived Experience (Peer) Workforces.

The development of the Lived Experience (Peer) Workforces is dynamic and a dedicated webpage will accompany and complement this Framework and supporting resources.

Thank you to everyone who brought their heart, energy and expertise to this work.

<sup>3</sup> Note the term Family Member/Significant Other is used in preference throughout this document. Further details about this is provided in the Workforce Diversity section of this Framework.



# Introducing contemporary Lived Experience (Peer) Workforces

**This introduction highlights the foundations of the Lived Experience (Peer) Workforces, and describes their origins, values base, uniqueness and the breadth and type of workforce roles.**

This Framework includes the Personal Lived Experience (Consumer) and Family/Significant Other workforces. There are commonalities and unique differences between the workforces and these are detailed further in the document. The development of the Family/Significant Other workforce is particularly important to ensure the needs of children and young people are identified and addressed. These roles may be combined within mentor roles in the First Nations workforce.

The Framework covers the mental health, alcohol and other drug and suicide prevention sectors and both paid and volunteer roles. It is recognised that these workforces across the sectors may have different role types and practise distinct ways of working. These distinct ways of working and role types are informed by different ways of understanding and experiences therefore have differences in the way the foundational values and principles are applied. These workforces will be collectively referred to in this Framework as the Lived Experience (Peer) Workforces. Lived Experience (Peer) Workforces that are across the mental health, alcohol and other drugs

and suicide prevention sectors are grounded in and draw on the histories of social and civil rights movements that were, and are, led by grassroots groups and communities<sup>iv</sup>.

These social movements have often begun in protest at injustice and discrimination, and they advocate for change to service and institutional responses<sup>v</sup>. The movements provide solidarity, empowerment and support. Drawing from these social movement foundations, Lived Experience (Peer) Workforces' responses are grounded in values of self-determination, freedom and social justice. Such efforts include mutual peer support and advocacy approaches which highlight the power of language and meaning.

These ideas seek to be open to different worldviews: the collections of attitudes, values, stories and expectations about the world around us which inform our every thought and action. Different worldviews and ways to understand experiences (explanatory frameworks) make it possible to use the explanation that fits best for the experiences, knowledge, culture of the communities in question

when responding to mental health, problematic alcohol and other drug use or suicide prevention challenges (social, cultural, spiritual, psychological, trauma, political, or biomedical). This kind of approach takes us beyond a 'one dominant size fits all' lens toward a more person-centred, holistic, rights-based response<sup>vi</sup>.

**“ I used to think I heard voices because I had a mental illness but now I know I hear voices because of my childhood trauma. This has been helpful and empowering.”**

– Hearing Voices Network participant

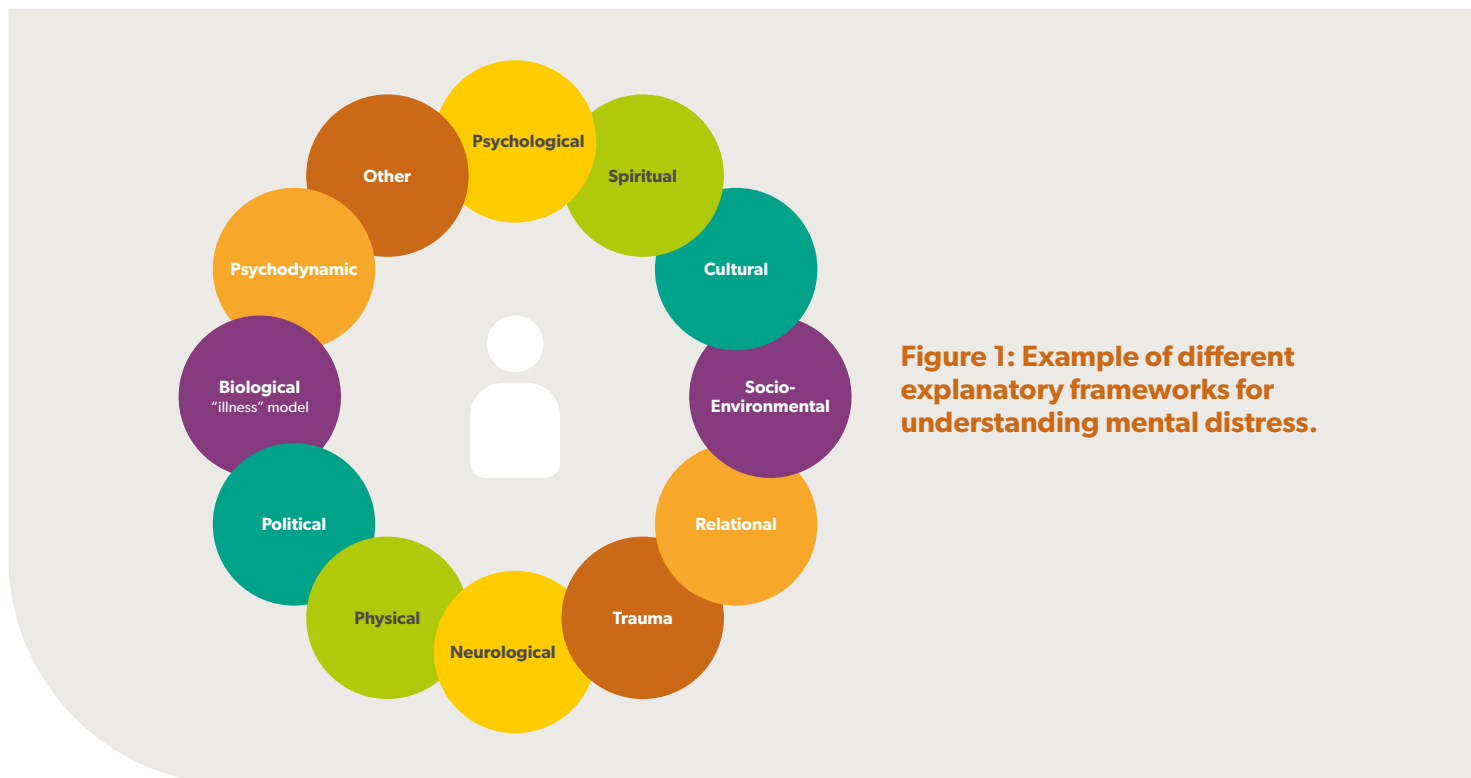


“The psychosocial model has emerged as an evidence-based response to the biomedical paradigm. It looks beyond (without excluding) biological factors, understanding psychological and social experiences as risk factors contributing to poor mental health and as positive contributors to well-being.”

– (UN Special Rapporteur on Health 2017)

The thoughts, feelings, emotions, perceptions and behaviours that are often framed as ‘mental illness’, ‘mental health issues’, ‘suicidal distress’ or ‘challenging behaviours’ are viewed and responded to as meaningful human responses to unreasonable or unjust social conditions or determinants<sup>vii</sup>. This is different to the framing within a focussed bio-medical model which views such responses as symptoms of disorder within an individual requiring medical intervention<sup>viii</sup>. By using a range

of explanatory frameworks, services are better positioned to respond to people in *their* context, in ways that focus on promoting and resourcing a quality life<sup>ix</sup>. This can happen whether a person is experiencing stressors due to social and health inequalities. Lived Experience (Peer) workers can help individuals to understand these different worldviews and help them decide which works best for them.



**Figure 1: Example of different explanatory frameworks for understanding mental distress.**

This diagram highlights that there are many ways to explain human distress. It is important to recognise that when one framework (such as the ‘illness model’) is dominant, it silences and marginalises other ways of knowing and explaining human experience and or distress<sup>x</sup>.

That is, when a person is given a definitive, categorical explanation (such as you have schizophrenia/bipolar etc.), the search for meaning often

stops (or pauses), and the fact that there are other ways to understand or explain one’s experience along spiritual, political, social/environmental or cultural contexts is hidden. These contexts may include poverty, violence, abuse, trauma, racism, homophobia, patriarchy and so forth.

Additionally, there are overlapping and intersecting experiences of race, culture, class, age, gender, sexuality, (dis)ability etc. that also impact people

as relational human beings. To narrow emotional distress and its impacts to purely a biological cause limits the potential pathways to recovery/ wellbeing and full citizenship.

The most important question this diagram seeks to ask is ‘does the framework I have been given help me to access the resources and supports to live a quality life?’



It was from the lived experience movements that the trauma-informed and recovery/wellbeing approaches were developed. Lived Experience (Peer) workers are living examples of hope and possibility. Lived Experience (Peer) workers draw on their personal or family / significant other /kinship experiences of distress, hope and healing. These **experiences** combined with Lived Experience education, training and peer supervision help people to develop their **lived experience expertise**. This lived experience expertise is the essential requirement to be a Lived Experience (Peer) worker.

The role of Lived Experience (Peer) Workforces as 'change agents' for system and service transformation has been reflected in a number of high-level national and state reports, which are included in the References section. Any such transformational process cannot rest on the shoulders of one group alone. It requires understandings translated to effective actions and courageous commitment to structural, policy and practice changes by and with allies and agents alike. These reports call for Lived Experience (Peer) Workforces to be embedded as an essential part of mental health, alcohol and other drug and suicide prevention responses. As a result, Lived Experience (Peer) Workforces are now being commissioned at all levels within mental health, alcohol and other drug and suicide prevention.

Embedding sustainable Lived Experience (Peer) Workforces requires:

- building capacity for Lived Experience leadership and Lived Experience governance.
- building systemic and other professional workforce capacity.
- systems and services to ready themselves and to show willingness to unlearn, learn and change how they do business to achieve better outcomes, using the workforces as a key enabler in that journey.
- developing career pathways, diversity of designated roles and contemporary, equitable remuneration awards.
- organisations to ready themselves for this change to build on previous changes that were and continue to be needed to deliver genuine trauma-competent and recovery/wellbeing, quality life focussed services.

The intent of this Framework is to provide a contemporary approach to developing these workforces in Western Australia while responding to the specific needs of WA's population and settings. This requires:

- distinguishing what is 'peer' from what is not 'peer' so as to develop solid top down and bottom up Lived Experience (Peer) governance mechanisms in order to avoid token protocols which are merely tweaks to the current system.

- identifying the distinctions within and across the mental health, alcohol and other drug and suicide prevention sectors and across the regional, rural, and remote landscape.
- understanding and respecting the cultural security of the Lived Experience (Peer) Workforces within Aboriginal and Torres Strait Islander communities.
- ensuring that Lived Experience (Peer) Workforces are developed within and for specific communities such as those additional to, and included, under the LGBTQIA+SB umbrella as well as in ELD communities.
- building understandings and connections across sectors so that a person can be responded to as a whole human being within a family and community context.

This Framework will be complemented by supporting resources focussing on key areas including a Toolkit for Organisational Actions, First Nations Lived Experience (Peer) Workforces and the wider diversity of the Lived Experience (Peer) Workforces.

## Language within this Framework and the contemporary workforces

The language around the workforces varies between sectors and is dynamic within them. For example, in the alcohol and other drug sector the preferred language to describe informal networks is 'family and significant other'. In First Nations communities, the term 'mentor' would be more commonly used to describe the peer role and there would not necessarily be the same distinction between consumer and family/significant other roles. Further notes on language are provided in the supporting resources that will accompany this Framework. It is recognised, however, that language evolves and will continue to change as the workforces develop.

The term 'Lived Experience (Peer) Workforce' has been adopted from national research which informed the

development of the 2021 National Lived Experience (Peer) Workforce Development Guidelines. Rather than being understood as limited to a direct consumer support role, the contemporary language shifts the focus to reflect the range of roles within the workforces. The plurality to 'Workforces' highlights the inclusion of both Consumer and Family/Significant Other workforces whereas traditional understandings have focussed mainly on consumer roles. The term 'Lived Experience (Peer) Workforces' also allows a more effective identification of the lived experience and expertise a person needs to fulfil specific roles. For example, a Lived Experience Consumer (Peer) representative who is advising at a strategic level on better

options for people with mental health in prison needs to have lived experience and expertise gained from having been in prison with mental health, alcohol and other drug challenges.

The term 'Designated' Lived Experience (Peer) role indicates a role which makes lived experience expertise an essential requirement in addition to the relevant practices, skills and knowledge and the peer work values needed for the role. The recent appointment of Lived Experience Director roles within Australia at senior state and federal government levels signals how designated Lived Experience (Peer) roles are increasingly being developed in a broad range of settings and at all levels, including on Boards.

**“These ideas around connection and community with a focus on emotional and social wellbeing are at the heart of contemporary LE (Peer) work practice.”**

– Lived Experience (Peer) Workforce Project Steering Committee member, Lyn Mahboub







Figure 2 below provides a descriptor of Sample Lived Experience Roles.

Figure 2: Sample Lived Experience Roles					
The following roles are ALL Lived Experience roles (but may have different role titles e.g. Family-Carer Peer Support Worker, Aboriginal Mentor, Consumer Consultant etc). These roles may be within government, NGO <sup>4</sup> , private hospitals and agencies, as well as groups or individuals as Owners/Directors of their own businesses <sup>4</sup> .					
Frontline Peer Worker	Leadership Roles	Advocacy	Education (Across academia, community and organisations)	Policy	Research and Evaluation
Peer Support Worker Senior PSW	Board Director	Representative	LE (Peer) Trainer, Facilitator, Educational assessor	Planning	Reviewer, Assessor
Peer Mentor	LE CEO including of a peer-led organisation	Consumer Consultant, Family-Carer Consultant	LE Educator	Advisor	Planning
Aboriginal Mentor	Senior Executive	Advisor (design, delivery, LE Governance)	Cert IV Peer Support LE Educator	Writer	LE Researcher
Traditional Healer <sup>5</sup>	Director Cultural Advisor	Strategic Advisor	Aboriginal Cultural Educator	LE HR Advisor on recruitment, retention	LE Research Assistant Associate Researcher
Peer Specialist	Manager, Coordinator	Indigenous Procurement Strategist	Developer, Designer		
Peer Group Facilitator	Team Leader	Independent Lived Experience Consultant	Lived Experience Academic (Consumer / Family Member)		
Aboriginal Consumer Participation Coordinator	Supervision Facilitator	Advocate	Peer Group Facilitator		
Aboriginal Liaison Officer, Cultural Advisor	Independent Peer to Peer Supervisor	Champion	Independent Lived Experience Academic		

The term ‘Non-Designated’ role indicates a role that does not require as essential lived experience expertise. These roles may be occupied by someone who has personal or family / significant other lived experience but whose professional practice is determined by the values, principles and scope of their professional discipline relating to the role (for example a social worker, counsellor, health worker, nurse). They have also

not been required as an essential part of their role to develop expertise in drawing on their lived experience, to be connected with the larger social movements and to receive peer supervision to maintain the integrity of their role.

The distinction between designated and non-designated roles is an important one as it speaks to the requirement for expertise to be used as an essential

part of a role, as distinct from a personal choice to draw upon it, or not. It also identifies the distinction between lived experience expertise which is required in a workplace role and lived experience of which we all have some element. The capitalisation of the L and E in the workforces’ title is deliberately used to highlight that difference and also to signal the breadth of the fast-developing Lived Experience (Peer) discipline.

<sup>4</sup> Such as the Indigenous Consulting Group – [www.icgaustralia.com.au/icg](http://www.icgaustralia.com.au/icg)

<sup>5</sup> It is noted that whilst Traditional Healers certainly engage with individuals and families in “frontline” settings, they may not align with the term “peer”, given that Traditional Healers have non-experience based expertise and seniority of status that make the “peer” term potentially misleading. This is further explored in the supporting resource dedicated to the First Nations Peoples Peer Workforce.

# The WA Lived Experience Workforces Framework

## Purpose of this Framework

The WA Lived Experience (Peer) Framework is intended to support individuals and organisations as they go forth to build, develop and strengthen the WA Lived Experience (Peer) Workforces. The foundations of this Framework – as with other Lived Experience (Peer) Workforce frameworks – have already been set in history as outlined in the Transformational Agents section of this Framework. Its many components provide a firm structure to ensure that the workforces will further develop over time.

The purpose of the Framework is to:

- Provide strategic direction within a WA context
- Reinforce Guiding Principles for embedding LE Peer Workforces
- Define the culture shift needed for transformation
- Provide recommendations for action



Figure 3: WA Lived Experience (Peer) Workforces Framework.



**“ It’s about asking  
what has happened  
to you not what’s  
wrong with you.”**

– WA Lived Experience (Peer)  
Practice Expert Group

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## Who is this Framework for?

- 1 It is for the people who are in or heading into a Lived Experience (Peer) Work role.
- 2 It is for funding bodies who seek to commission and fund organisations to build their Lived Experience (Peer) Workforces.
- 3 It is for organisations who are seeking to learn how to develop lived experience led strategies and actions to engage thriving and sustainable Lived Experience (Peer) Workforces.

It encompasses the Western Australian mental health and alcohol and other drug sectors and includes consideration of First Nations Peoples, alcohol and other drug, suicide prevention and mental health Lived Experience (Peer) Work.

## Guiding Principles



**Figure 4: Guiding Principles for Lived Experience (Peer) work**

These principles were generated in a co-design process during the development of this Framework, for and by people with lived experience and peer workers. Members of the Peer Practice Expert Advisory Group reflected on peer work and lived experience principles (and what they looked like in practice) from nine interstate and international sources. They identified six principles that held true for Lived Experience (Peer) workers in the mental health, suicide prevention and alcohol and other drug sectors. The final principles are intentional, purposeful and deliberate. These principles were also mapped against the guiding principles and core values of Lived Experience work outlined in the National Mental Health Lived Experience Workforce Guidelines to ensure alignment and consistency.



## Connection

Connection is the cornerstone of peer work, providing a space where relationships can be cultivated and sustained. Safely and intentionally sharing experiences fosters deeper connections so people feel heard and understood. It provides a place where the seeds of hope and optimism can grow. It's about sharing experiences, building trust and safety, being understanding and non-judgemental.

### What it looks like in practice:

- Conversations with a purpose
- Empathy and understanding
- Validating of people's experience
- Offering and discussing options for change
- Sharing of self-care and resilience strategies

**Peers hold a space for exploration and discovery in the relationship.**



## Authenticity

Authenticity means bringing your true self to the work while knowing your boundaries and limitations. A willingness to work in developing our own identity and support others in developing theirs too. It's about being genuine and honest, including what we can and can't do. Working with deliberate attentiveness and responsiveness because we have been there too.

### What it looks like in practice:

- Showing vulnerability
- Being present
- Following through

**It's about asking what has happened to you not what's wrong with you.**



## Diversity

Appreciation for diversity of thought and diversity of beliefs and an understanding that each person's way is the right way for them. It's understanding and accepting yourself and others as they are. It's an openness to embrace different world views and ways of being.

### What it looks like in practice:

- Self-awareness
- Being welcoming and inclusive
- Being curious in conversations
- Willingness to develop and learn
- Reflective practice

**Respect for individual approaches to wellbeing.**





## Humanity

Humanity is about recognising the inherent value of all individuals who are shaped by life experiences and are deserving of respect, opportunities and compassion. Peers have an antenna for others' sensitivity and an awareness of the human condition.

### What it looks like in practice:

- Being kind and caring
- Showing compassion
- Listening deeply
- Person first

**Having compassion for others is grounded in being compassionate towards yourself.**



## Mutuality

For peer workers, mutuality means bringing the qualities of genuine friendship to peer work rather than a professional to client relationship. It's about intentionally developing and maintaining a two-way, equal relationship based on the kinship of common experience. Peer workers support people by 'being with' rather than 'doing for'. People learn and grow from each other through this peer relationship.

### What it looks like in practice:

- Sharing power
- Seeing others as equals
- Allowing for change
- Showing humility

**It's the ability to know where you are at and the ability to meet people where they are at.**



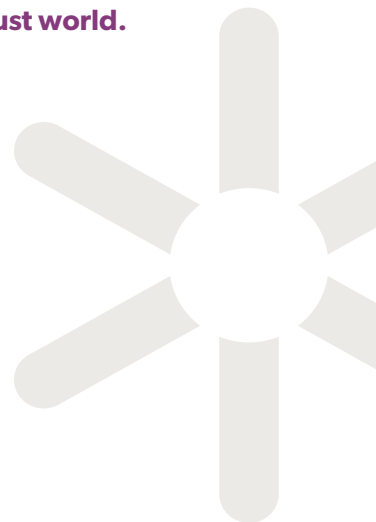
## Human Rights

Peer workers support people's right to freedom and choice. It's a commitment to fairness, equity and 'a good life'. Peer work involves working towards justice and rights for all people, to support inclusion and strong communities. This transformational work whether at an individual, service or system level takes time and courage.

### What it looks like in practice:

- Supporting
- 'Staying with'
- Stepping and speaking up
- Advocating
- Promoting equity

**Peers work to advocate for a socially just world.**







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# Lived Experience (Peer) Work

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## What is Lived Experience (Peer) Work?

The National Mental Health Workforce Development Guidelines acknowledges and promotes Lived Experience (Peer) Work as a discipline in its own right.<sup>xii</sup>

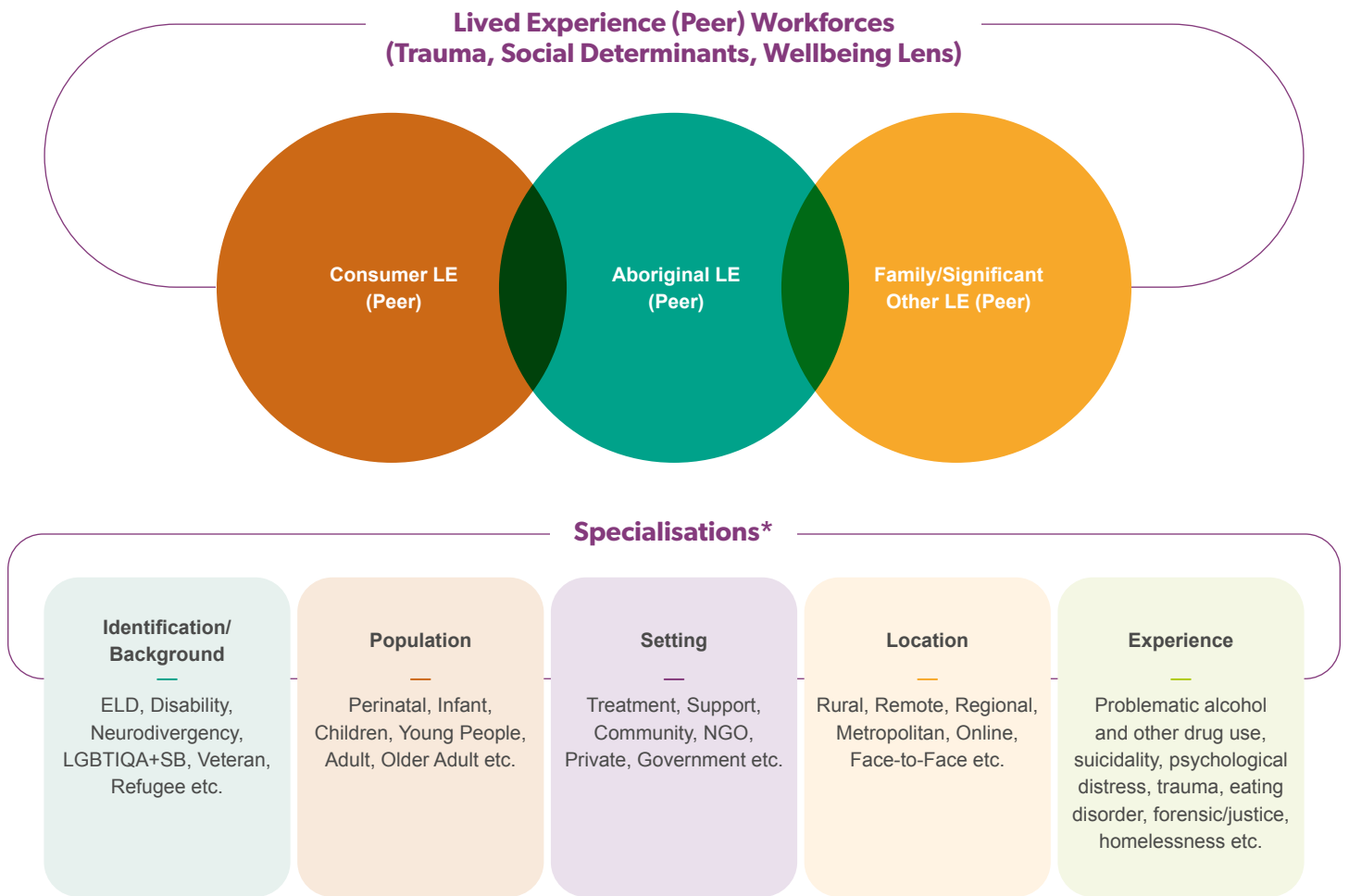
Lived Experience (Peer) work incorporates understandings of the diversity of communities (and diversity within communities), identities, lifespan, and experiences of distress and service use. It is grounded in social and relational understandings of thoughts, feelings, beliefs and perceptions. It is organised around the idea that *we are all relational beings, rather than beings in relationships*.<sup>xiii</sup>

The mental health, alcohol and other drug and suicide prevention sectors have different histories and different approaches to integrating lived experience expertise. However, these sectors have arisen out of traditional beliefs about the nature of distress that are superseded by both the SEWB model (as outlined further in Figure 8) and lived experience expertise. Many people have cross-sectoral and cross-community lived experiences that require different approaches in response. This Framework is intended to ensure collaborative and strategic developments across the workforces and existing sectors are progressed in ways that recognise these realities.

The Lived Experience (Peer) Workforce Framework is comprised of three distinct workforces – the Aboriginal Lived Experience (Peer) workforce, the Consumer Lived Experience (Peer) workforce, and the Family/Significant Other Lived Experience (Peer) workforce. Further specialisations within these workforces also exist, derived from shared lived experiences. For example, the role of a direct support Consumer Lived Experience (Peer) worker in a rural setting will differ from that of a LGBTQI+SB Consumer Lived Experience (Peer) worker in a busy city Emergency Department. However, the values base and fundamental Lived Experience discipline will be the same.

Figure 5 on the next page sets out some of these specialisations for illustrative purposes and is not exhaustive.

Figure 5: Lived Experience (Peer) Workforces and Specialisations



Lived Experience (Peer) Work

*\*This list of specialisations is for illustrative purposes and is not exhaustive.*



## Trauma, adverse life experiences and social determinants

It is a core tenet of the Lived Experience workforces that they respect different views and allow for multiple perspectives. It is also a core principle of recovery and wellbeing that each person's experience will be individual and different from that of others.

However, the Lived Experience Workforces are grounded in the relationship between mental health, substance use and suicidal thoughts, feelings and/or actions and wide scale inequality in social determinants. These social determinants may include impacts of:

- racism, sexism
- gender and sexuality-based discrimination
- family and domestic violence

- child removals and other forms of childhood trauma
- denial of access to traditional lands and language
- lack of access to housing, employment, education, services
- socioeconomic status<sup>xiv</sup>

These disparities in social and economic conditions disproportionately affect marginalised communities, including impacting the SEWB of First Nations Peoples.

For ethnoculturally and linguistically diverse communities, these experiences may be compounded by specific experiences of trauma such as torture, the impact of war, forced migration, and dislocation.

Lived Experience (Peer) Workforces operate from a recovery/wellbeing oriented framework and have been leading this movement. Although we note some adoption of the recovery/wellbeing oriented framework within the medical approach over recent years, the historical features of these models demonstrate the different positioning of these workforces in practice.

**Figure 6 below shows how each of the workforces can support a quality life.**

The diagram adapted from Lyn Mahboub's Facilitating social, emotional cultural and spiritual wellbeing for a quality life (2017) includes the Outcomes Measurement Framework for Community Services in Western Australia<sup>xv</sup>.

**“I chose peer support services because it is great to talk to someone who has been through it and who is doing well. It gives me hope that I can get through this.”**

– HelpingMinds participant





## What are specific qualities of Lived Experience (Peer) Work?

Figure 7 below from the National Guidelines provides a starting point for understanding the unique qualities of Lived Experience work highlighting its specialist knowledge and experience base<sup>xvi</sup>.

### Unique knowledge, abilities and attributes.

- Profound life-changing mental health, alcohol and other drug and/or life challenges that have led to a new life direction and concept of self or life-changing experiences while supporting someone with mental health challenges that have profoundly impacted their life/world view.
- Personal identification with, and experiences of service use and/or advocating for someone using services.
- Understanding experiences of marginalisation, exclusion, discrimination, loss of identity/human rights/citizenship.
- Willingness to purposefully share experiences and 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 hopelessness to one of hope.
- Willingness to use emotional understanding and knowing as key to work role.
- Willingness to be vulnerable and publicly 'out'.
- Understanding 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?

- Applying 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 consumer movement and concepts.
- Work that is values-based and authentically lived experience-informed, person-directed and aligned with recovery principles.
- A social justice and fairness focus informed by understanding power imbalances.
- Significant understanding and ability to use personal story effectively and appropriately, for the benefit of the other person or system/service reform.
- Convey or inspire optimism and hope.
- A bridge between organisations and people accessing services/supporting people accessing services.
- Understanding of overlapping identities and experiences (intersectionality) and the impacts of culture and identification.
- Trauma-informed: awareness of the role/impact of trauma and how to respond sensitively and appropriately.
- Resilience in the face of discriminating, prejudicial and disempowering attitudes, practices and policies.
- Focus on the relationship.
- Greater flexibility/scope/ability to be responsive to the person, rather than being driven by a prescribed agenda.
- Specialisation may be useful depending on the context and experience e.g. people from the Deaf community, Youth, people with experiences of family violence etc.



# Workforce diversity

## First Nations Peoples Lived Experience (Peer) Workforce

The First Nations Peoples Lived Experience (Peer) Workforce is based on different concepts of mental health, substance use and suicide prevention from the mainstream service systems. This is because the conception of self is grounded within a collectivist perspective that views the self as inseparable from, and embedded within, family and community.<sup>xvii</sup> The SEWB model “incorporates an ecological, collectivist perspective of self that is intrinsically embedded within family, community and extended kinship and clan group networks. Connections to land, culture, and spirituality shape these networks. Mental wellbeing is an important component of SEWB but needs to be viewed as only one component of health that is inextricably linked to the social, emotional, physical, cultural, and spiritual dimensions of wellbeing.”<sup>xviii</sup>

Aboriginal and Torres Strait Islander Lived Experience Centre 2020 state that the First Nations Peoples Lived Experience (Peer) Workforce defines ‘lived experience’ as recognising “the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of First Nations Peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.”<sup>xix</sup> Additionally when referring to a lived or living experience of suicide, it is acknowledged that the experience is significantly different for people with lived or living experience of suicide (or caring for, or bereaved from suicide) and the SEWB impacts within First Nations Peoples and their communities.<sup>xx</sup> Given this perspective, greater significance is therefore placed on the role of kinship,

interconnectedness, community wellbeing, and spirituality. These differences are often demonstrated using alternate terms, including ‘spiritual imbalance’ and ‘strong spirit’ in describing and understanding experiences.

For example, Wungening Aboriginal Corporation note the term “*Djandoo Wirin Koonger*, symbolising together in mind and body and the connection through lived experience, and the connection to go forward together<sup>xxi</sup>.”

It is important that individuals are offered a choice, not just linked in with a First Nations Peoples Lived Experience (Peer) worker because they are also a First Nations person. There may be cultural obligations and traditional ways that prevent them from working with particular people.

Workforce diversity



Figure 8: Describes a model of social and emotional wellbeing.

SEWB Diagram adapted from Gee et al., (2014)



## Lived Experience (Peer) Consumer and Family/ Significant Other Workforces

While many Lived Experience (Peer) workers have lived experiences both as a consumer and as a family member/ significant other, it is essential to be clear about the differences and tensions between the two workforces (as well as the commonalities). Singling out one part of one's identity from which to work or advocate takes deep consideration and thought. When working in delineated roles, it is important to do so **from the perspective of that role only as the roles are not interchangeable**. Maintaining this clarity of perspective is supported by access to skilled Lived Experience (Peer) supervision. This is especially important in small organisations, communities or rural areas when there may be no lived experience expertise available, in order to ensure that people maintain the integrity of their role.

While both aim to promote personal recovery and wellbeing through understandings of peer connection

to people and resources, in frontline services Consumer Lived Experience (Peer) workers work with consumers while Family/Significant Other Lived Experience (Peer) workers work with family or significant others. Similarly, in other roles within the system, Consumer Lived Experience (Peer) workers provide the perspectives of people with personal lived experience, while Family/Significant Other Lived Experience (Peer) workers provide the perspectives of families or significant others, including children, young people and families of choice.

The Lived Experience (Peer) Workforces draw on three integrated sources of knowledge and skills when working in designated Lived Experience (Peer) roles:

- their own lived experiential knowledge of trauma responses and healing.
- the collective lived experience trauma/social determinants-informed, recovery/wellbeing knowledge and

skills they are educated, trained and peer-supervised in.

- their ongoing professional development, supervision, networking and connection to their own community as well as other lived experience communities.

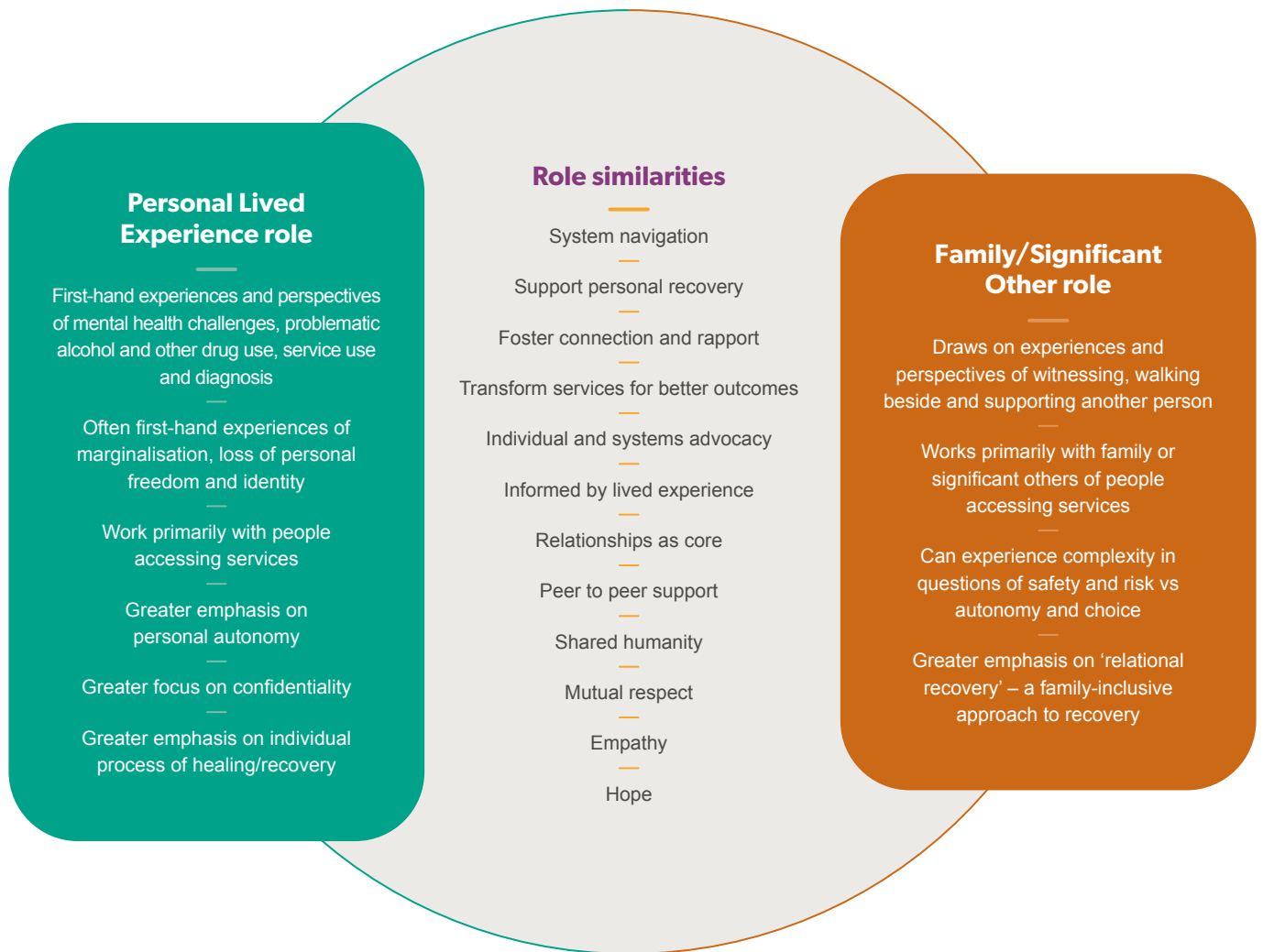
The key to qualification for Lived Experience (Peer) roles is that the impact of the experiences – whether of mental health challenges, problematic substance use or suicidal thoughts, feelings and/or actions, and whether based on personal or family/significant other experiences – caused life as they knew it to be so disrupted that the person had to reimagine their place in the world and their future plans.<sup>xxii</sup>





## The difference between Consumer (Personal) and Family/Significant Other Lived Experience (Peer) roles

The differences in the roles along with the similarities can be more easily understood in Figure 9 below<sup>xiii</sup>:



Workforce diversity



**No matter the lived experience perspective which Lived Experience (Peer) workers bring to their roles, the work is relational, trauma informed, addresses social determinants and a return to living a contributing life.**

– Derived from outcomes of Mental Health Commissions Lived Experience (Peer) Workforce Project consultation

## Consumer/Service User/Survivor/Peer Workforce

Consumer Lived Experience (Peer) workforce roles require deliberate work to position themselves and their own experiences within the rights, social justice and relational understandings of mental health, substance use and suicidal thoughts and feelings and to go beyond personal understandings and ideas. It also requires integration of their own recovery within lived experience understandings and

awareness of trauma, other social determinants, power and control operating in their life, and healing<sup>xxiv</sup>. The personal experience is an essential component for the lived experience worker, however the incorporation of training and development and understanding greater social and civil rights movements creates the expertise to draw on wider understandings than one's own experience.

It is important in recruiting to leadership and governance positions that non-frontline Lived Experience (Peer) roles prioritise and draw from lived experiences of discrimination, impoverishment, loss, invalidation and other forms of trauma. Otherwise the system unconsciously defaults to a clinical dominance in system design for historical reasons.

## Family/Significant Other Lived Experience (Peer) Workforce

Family/Significant Other Lived Experience (Peer) roles utilise a whole-of-family lens, including children. The term Family/Significant Other is a broad term that is inclusive of the terms Carer, Family/Carer, Support Person, among others, that are sometimes referred to in the mental health and alcohol and other drug space. These roles require intentional positioning within a rights-based, social justice and relational understanding of mental health, problematic substance use and suicidal thinking and feeling. The perspective of the role is also often balanced

by heightened awareness of, and fears about, safety and risk. Family/Significant Other (Peer) roles draw on lived experiences of witnessing, walking beside, being impacted by, loss, grief (ambiguous, disenfranchised and real) and supporting someone experiencing mental health challenges, problematic alcohol and other drug use or suicidal thoughts, feelings and/or actions, or bereavement from suicide. They also draw on their own experiences of regaining wellbeing as individual family members and of whole-of-family recovery. Family/

Significant Other Lived Experience (Peer) workforce members emphasise the importance of relationships and family-responsive approaches to recovery and wellbeing. These roles require attention to the complexities of the broader consumer perspectives which encompass different individual experiences with their family/significant others and the impact of coercive treatment and discrimination that occurs within society, systems and sometimes families.





**“ The word diversity is often used in workplaces in the Lived Experience (Peer) space but sometimes they are only talking about one aspect of diversity, like multicultural inclusion, or gender diversity, not taking all diversity in. The Lived Experience (Peer) space is stronger with more diversity in all aspects of the word and not just one facet.”**

– Lived Experience (Peer) contributor to this Framework

## **Workforces for Diverse Experiences and Diverse Communities**

The unique discipline of the Lived Experience (Peer) Workforces is based on shared understandings and experiential knowledge. In service design at a strategic level on a cross-sector initiative, for example, it is critical that a Lived Experience (Peer) Strategic Advisor with a lived experience of navigating cross sector services be recruited to the role.

At a frontline level, for instance, it is best practice to link a Lived Experience (Peer) worker with an individual who shares common experiences of personal challenges and adversity (for example distress, trauma, problematic alcohol and other drug use) rather than assume that lived experience is transferable to all people.

This requires the intentional growth of specialisations within the workforces, as described in Figure 3.



# Productivity

## Benefits of the Lived Experience (Peer) Workforces

The unique contributions of the Lived Experience (Peer) Workforces are innovative and contemporary. The World Health Organisation<sup>xv</sup> has identified many key benefits Lived Experience (Peer) workers deliver to people accessing services, their families/significant others and organisations, ranging from increased satisfaction with services to recovery outcomes and cost savings.

The National Lived Experience (Peer) Workforce Development Guidelines also outlines a range of benefits of well-supported Lived Experience (Peer) Workforces in Figure 10 below.

**“ Every major innovation in mental health in the last 20 years has been led by peers, starting with recovery and peer support which have been fundamental.”**

– (Cohen, 2019)

### Benefits for families, carers and social networks

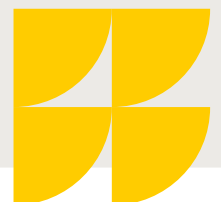
- Lived understanding aids rapport and relationships built on connection and trust
- More equitable relationships
- Foster a sense of belonging/ community
- Focus on human rights/ social justice
- Living example of hope
- Increased empathy
- Advocacy
- Mutuality

### Benefits for people accessing services

- Risk averse approaches replaced by dignity of risk
- Lived understanding aids rapport and relationships built on connection and trust
- More equitable relationships
- Foster a sense of belonging/ community
- Focus on human rights/ social justice
- Living example of hope
- Increased empathy
- Advocacy
- Mutuality

### Benefits for organisations and colleagues

- Greater recovery understanding/ orientation
- Contributes to more person-directed approaches
- Co-production leads to safer and more accountable services
- Contributes to more inclusive, flexible, resilient work culture
- ‘Bridge’ of understanding between people accessing services and colleagues in traditional roles
- Reduced need for ongoing formal support and hospitalisation



## Benefits for People Seeking Services

The WA Peer Support Network (WAPSN) has identified a range of reported benefits for people with mental health challenges and/or problematic alcohol and other drug use, their families, carers and significant others who have received peer services.

They include:

- enhanced quality of life
- increased hope, wellbeing, self-care and community participation
- improved personal outcomes, such as enhancing mental health recovery and wellbeing
- reduced stigma and enhanced social inclusion
- enhanced engagement in health promotion and harm reduction initiatives<sup>xxvi</sup>

## Economic benefits

The available evidence suggests that Lived Experience (Peer) work may be effective in reducing hospital admission rates. Peer work has been used successfully in a range of programs to support people to make a successful transition to the community after a hospital admission. Peer work can also be provided to people who may be at risk of readmission<sup>xxvii,xxviii</sup>.

In NSW the Peer Supported Transfer of Care (Peer-STOC) has recently been evaluated<sup>xxxiii</sup>. The Peer-STOC is designed to provide additional person-centred and recovery focussed supports to individuals with complex mental health needs during a 6-week period of transition to home or community after an inpatient admission.

### The social return on investment (SROI)<sup>xxix</sup>

**\$3.27**

#### Return on Investment

For a 100% peer operated service. For every \$1 invested, approximately \$3.27 of social and economic value is expected to be created.

### Reduced hospital admissions mean reduced beddays<sup>xxx,xxxi,xxxii</sup>

**\$20,768,809<sup>pa</sup>**

#### Savings

If a LE (Peer) supported hospital discharge program had the potential to reduce bed days by a conservative 5%. The cost of mental health bedday is \$1,618. There was 256,722 patient days in 2020-2021.

**“ The most significant change in alcohol and other drug and mental health service delivery for good outcomes I have seen in my 20 years plus career.”**

– A comment from a health professional regarding the impact of the peer workforce. WA Peer Supporters’ Network. 2018 The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services.



## The impacts of Peer-STOC on the health system include:



**7,904**

bed days released  
over 3 years



**\$1,846,834**

net benefit to the health system  
over 3 years



For every **\$1 invested**  
in Peer-STOC it returned  
**\$1.85 in benefits**

## Impacts for consumers include:



**8.6 fewer**

days in hospital per year



**32% fewer**

individuals readmitted within  
28 days



**\$12,211**

annual net savings per  
participant

## Themes from interviews and surveys (n = 140)



A better, less traumatic  
inpatient experience



Built and re-established  
community connections



**54% more**

community-based contacts



Felt understood, cared about  
and less alone



Gained new strategies,  
knowledge, understanding  
and skills



**13%  
recovery**



Easier to leave hospital



More hopeful about my recovery



**11%** doing things I value



**13%** looking forward



**20%** mastering my illness



**9%** connecting and belonging



Easier to get back into daily life  
and routines

## Sector and Systems Benefits

Sector and system level Lived Experience (Peer) workers work with groups of people and organisations to change legislation, policy and service practices to produce transformational long-term changes. System level Lived Experience (Peer) workers benefit all stakeholders including individuals, family/significant others, services and the wider community by:

- contributing a person-centred approach to recovery/wellbeing with all stakeholders including the other health professionals and community

- improving service design, planning, delivery and evaluation
- promoting access to treatment, support and care that works for them
- promoting understanding of the social determinants that impact wellbeing
- demonstrating that people with lived experience can and do perform at all levels in the workforce
- reducing stigma and discrimination

Resulting in:

- people with a lived experience being understood and valued
- people with a lived experience being involved in and leading decisions that impact them
- human rights being upheld





# Transformation agents



## Histories and origins of Lived Experience (Peer) Work: Voices of the people

This section has been purposefully written from a collectivist first person, lived experience perspective to better encapsulate the evolution of the workforces.

A key value of Lived Experience (Peer) work is the recognition of those who came before us, on whose shoulders we stand, in order to recognise their contribution to the place we find ourselves in today. It is thanks to their efforts that we commence from today's strong foundation which this Framework sketches. The following **histories** acknowledge those giants, leaders and everyday folks who played a part, by bringing their various voices and positions to the fore. The origins of Lived Experience (Peer) work vary according to the different contexts in which it has emerged. These include First Nations contexts, mental health contexts, alcohol and other drug contexts and suicide prevention. The following is a history of outcry from the voices of **the people**, as differentiated from a history of government policy, or organisations. It is worth noting that by **the people** we are referring to those of us who have lived and living experiences, that are 'on the ground' and from the 'grass roots' of this emerging movement.

We don't live in 'sectors', nor is our thinking centred around services (service-centrism); rather we are driven by our real-life contexts, issues and mission to have a quality life and the resources with which to do so, which many call 'recovery'. We are living lives often in difficult circumstances which may be due to a range of factors such as structural inequality (such as racism, homophobia, sexism), trauma (historic, trans generational, including violence, abuse and neglect), and social determinants (such as poverty, unemployment, insecure housing, food insecurity). Given the resulting impact on our wellbeing we find ways to cope as best we can, often within limited resources and conditions.

In many ways, what follows is a history of protest *and* self-empowerment. Such protest signals the contribution that people with lived experience can make toward turning responses that have been harmful (or less than helpful) into responses that meet people's needs. This history simultaneously signals the belief in, and value of, doing it 'on our own' (peer led and centred).<sup>6</sup>



<sup>6</sup> The mother of the mental health consumer movement, Judy Chamberlin's (1978) book *On our own: Patient-controlled alternatives to the mental health system* speaks to this. Similarly, both mutual support groups such as AA, GROW (founded in Australia in 1957) and peer support groups like Hearing Voices Approach and Alternatives to Suicide demonstrate this.

## Snapshot



### 1600s

Ex-inmates, family, friends and allies make changes to how people in 'mad houses' or asylums are treated.

### 1700s

Temperance movement for the abstinence of alcohol use involving family members and friends.

### Late 18th century

Ax-asylum patients first employed within the institutions they had been detained in due to their ability to empathise with their 'inmates'.

### 1930s

Alcoholics Anonymous (AA) is formed as a peer support group for abstinence from alcohol.

### 1951

Al Anon (US) is formed by family members to support relatives and friends of people linked to AA.

### Late 1950s to 70s

The rise of 'people power':

- Civil right and social movements.
- 'Psychiatric survivors' including families and allies highlight oppression, social inequality and loss of human rights.
- Common cause with black rights, gay rights, women's rights, disability rights movements
- *'Nothing About Us Without Us'*

### 1969

Arnstein's 'Ladder of Participation'

- This was founded on increasingly prevalent ideas of 'citizen control' and 'citizen participation'.

### 1970s and 80s

Formation of a range of

- Activist groups including the *Mental Patients Union* (UK), *MindFreedom International* (US), *Campaign against Psychiatric Injustice and Coercion* (Australia).
- Advocacy groups such as the *World Network of Users and Survivors of Psychiatry*.

### 1978

World Health Organisation Declaration of Alma Ata – "The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."

## Alcohol and Other Drug Peer Work

Over time, people with a lived experience of problematic substance use, their families and allies mobilised to form a range of organisations pertinent to problematic alcohol and other drug use. Nationally, over 65% of the drug and alcohol workforce identify as having relevant lived experience (personal, family, other) signals the lived experience foundations within

this workforce.<sup>xxxiv</sup> Many of this group are not employed in designated Lived Experience (Peer) roles. Rather, they may take up other roles such as counselling, nursing, social work, and community development that have their own professional discipline. Of the 65%, only 3% use their lived experience in designated Lived Experience (Peer) roles.<sup>xxxv</sup> This

notwithstanding, there is a recent history of alcohol and other drug peer-based organisations in Australia run for and by peers, such as Unharm (National), the Alcohol and Other Drug Consumer & Community Coalition (AODCCC) and Peer Based Harm Reduction WA.

## Aboriginal Peer Work

Peer work for First Nations Peoples around the world is culturally embedded and a big part of everyday ways of being and doing for First Nations Peoples and their communities.<sup>7</sup> Such reciprocal and community orientated (rather than individually focussed) ways of doing and being are ingrained in First Nations cultures, reflecting

practices that have been practised over thousands of years. These First Nations ways of being and doing are captured in the broader notion of SEWB, which is more extensive than Western conceptions of mental health. Sharing decision-making with First Nations Peoples is essential to improving relevant services noting

that consideration needs to be given to the commitment to grow First Nations peoples community-controlled organisations when considering expanding the Aboriginal LE/Peer workforce. This is supported by the 2020 National Agreement on Closing the Gap<sup>xxxvi</sup>.

<sup>7</sup> In discussions with the Aboriginal Workforce in the development of this Framework. Also see Wungening and WAPHA – AOD Workforce Capacity Building Project 2018-2019. Wungening Aboriginal Corporation.



**The knowledge and wisdom brought by people whose lived experience has significantly impacted their social and emotional wellbeing and quality of life is invaluable.**

– Derived from outcomes of Mental Health Commissions Lived Experience (Peer) Workforce Project consultation





## Mental Health Peer Work

“The people have the right and duty to participate individually and collectively in the planning and implementation of their health care”

– World Health Organisation. (1978). Declaration of Alma-Ata.<sup>xxxvii</sup>

This key concept came to be central to National Disability Rights agendas and Australian government policy within health. A central influence was *Australia’s National Inquiry into the Human Rights of People with Mental Illness* and its resulting Report by

Human Rights Equal Opportunity Commissioner Brian Burdekin. The Burdekin Report led to Australian mental health services standards mandating consumer and family involvement within *National Mental Health Service Standards*. Additionally, it is embedded across all of health as mandated within the *National Quality and Safety Standards* which require services to be *Partnering with Consumers*<sup>8</sup>. Such policies stress the importance of including ‘consumers’ in the design, delivery and implementation

of services and put people with lived experience firmly at the centre for the first time.

Over time, within mental health this led to the engagement of people with a lived experience (consumers and family/significant others) as representatives on committees and the employment of consumer consultants, advocates and peers within mental health services. These are considered the first paid Lived Experience (Peer) workers in Australia in clearly designated Lived Experience roles.

## Combined voices

The mobilisation of lived experience voices of protest has led to calls for better responses to suicide, mental distress and problematic substance use. Moreover, we have seen the emergence of lived experience led advocacy and peer support emboldening the development of harm reduction-based responses for people experiencing suicidal feelings and thoughts, substance use, hearing voices, and other distressing phenomena, beliefs and or extreme states. In particular, the unified call across mental health, alcohol and other drug and First Nations

Peoples peer groups is for a shift in focus from a deficits-based biomedical approach toward a focus on the social and structural determinants that are barriers interrupting the possibility of a quality life.

The formation of consumer peak bodies and carer-led entities in some states and territories and the establishment of Certificate IV Mental Health Peer Work qualification in 2012 has led to significant growth and opportunities in the Lived Experience (Peer) Workforces<sup>9</sup>. A timeline of the

development of the Lived Experience (Peer) Workforces in Western Australia is outlined in Figure 11 on the next page with more details to be found on the Lived Experience Workforces website.

Today the Lived Experience (Peer) Workforces are diverse and continuously growing as a profession. They are increasingly recognised as having experience, knowledge and expertise equal to that of other disciplines in the mental health, alcohol and other drug sectors and suicide prevention sectors.

<sup>8</sup> Standard 2 of the National Quality and Safety Health Service Standards 2021

<sup>9</sup> For more information see Meagher, Stratford, Jackson, Jayakody & Fong, 2018



## Figure 11: Milestones in the development of the Lived Experience (Peer) Workforces in WA

**“The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.”**

– Declaration of Alma Ata, World Health Organisation 1978

### PRE 1990s

- 1947 first WAAA meeting
- 1967 first Grow Group meeting
- 1974 first LGBTIQ+SB peer organisation incorporated in WA
- 1975 Holyoake established
- First paid LE (Peer) worker at Grow WA
- 1976 ARAFMI public meeting (now Helping Minds)
- 1981 Cyrenian House established
- 1982 WISH formed (now Connect Groups)
- 1984 Even Keel Bipolar Support Association founded
- 1984 WANADA established as peak AOD body
- 1989 informal peer support program at Fremantle Prison

### 1990s

- Late 80's early 90's WA Substance Users' Association established
- 1990 Schizophrenia Fellowship (MIFWA) incorporated
- 1991 first funded Sex Worker Peer workforce in WA and Australia
- 1992 Australia's First National Mental Health Plan released
- 1993 Burdekin Report into human rights and mental illness released
- Health Consumers Council Advocacy Project ran from 1995 – 2003
- Carers WA 1996 was established
- 1996 Parent Drug Information Service established





## 2000s

- 2001 Association of Mental Health Consumers formed
- 2003 Q-Life Peer services started
- 2004 Body Esteem Program began
- 2004 first LE (Peer) worker at a public community mental health service
- 2004 first 'consumer consultants' employed at public health service
- 2005 CoMHWAs incorporated
- 2005 Hearing Voices Network began
- 2005 State Wide Consumer Participation Program started
- 2005 Richmond Fellowship WA employs voice hearer peers
- 2006 first LE (Peer) worker employed within an inpatient ward
- 2007 HealthRight Project & Peer Advocacy and Support Service undertaken
- 2008 Graylands Hospital Peer Staff employed
- 2007 Personal Helpers and Mentors programs established, employing LE (Peer) workers
- 2007 first Statewide LE (Peer) Work Coordinator employed
- 2008 first LE (Peer) Academic at UWA engaged

## 2010s

- NGOs like Ruah, Vinnies and Neami create peer LE (Peer) programs
- 2010 Mental Health Matters 2 was founded by individuals and families
- 2010 Mental Health Commission established with a Consumer Advisor employed in 2011
- 2011 CoMHWAs as funded mental health consumer peak body
- 2011 Allies in Change program started (2015 in Kalgoorlie)
- 2012 Peer Work Qualification established
- 2012 Peer led and run Recovery Rocks established
- North Metro employs a comprehensive LE (Peer) Workforce
- 2015 Scholarship Program for Peer Work Qualification established
- 2015 PCH Peer Program established
- 2015 Broome Recovery College opened
- 2016 Outcare Peer Program starts
- 2016 Valuing Lived Experience Program at Curtin Uni initiated
- 2017 Choices Post-Discharge Program started
- 2018 The Wungening and WAPHA Workforce Capacity Building Project 'Djandoo Wirin Koonger'
- 2018 WACHS Peer Program initiated
- 2018 AOD Consumer and Community Coalition established
- 2018 LE (Peer) run Wellness Initiative established
- 2019 WA Recovery College opened

## 2020s

- 2020 Lived Experience representation in mental health and AOD governance structures
- 2020 Solid Steps AOD prison program starts
- 2020 CoMHWAs is funded to lead the ASPIRE Project
- 2020 Productivity Commission Inquiry Report released
- 2021 Safe Haven opened as a alternative to ED's
- 2021 CoMHWAs Peer Pathways, a peer navigation service started
- 2021 National Suicide Prevention Adviser Final Advice
- 2021 National LE (Peer) Workforce Development Guidelines released
- 2022 Momentum QP opened for young people, employing LE (Peer) workers
- All five public health service employ LE (Peer) workers
- 2022 Increased Peer Work qualification scholarships through State and federal funding
- 2022 the WA LE (Peer) Workforce Framework released
- 2022 Increased Peer Work qualification scholarships through State and federal funding
- 2022 Dedicated State funding allocated to implement initiatives to build the capacity of the LE (Peer) Workforce including the organisations that employ them
- 2022 Scoping of a LE (Peer) Workforce association underway.





The degree to which executive/ senior management value and understand lived experience roles, directly correlates to the commitment shown in developing and supporting lived experience workforce within organisations.

– Byrne, L. (2014)



# Organisational actions

## Organisational development

Lived Experience (Peer) workers thrive in trauma informed, person centred and innovative organisations whose operations are congruent with the values and practices of peer work. This entails a demonstrated commitment to reviewing organisational policies, processes and practices to ensure alignment.

Anecdotally Clinically focussed workplaces have often struggled to adjust to Lived Experience (Peer) work practices, as there is usually a bias or preference for 'corporate' or 'clinical' styles of working.<sup>xxviii</sup> There are clear similarities between the Lived Experience (Peer) Workforces and the broader First Nations Peoples workforce<sup>10</sup>. Relationships, connection, sharing power and blurring boundaries are features of these workforces but do not fit comfortably in hierarchically structured workplaces.

In order to embed the Lived Experience (Peer) Workforces in line with their

foundational principles and values-based practices, organisations need to adopt a culture of learning and unlearning at all levels. This includes Human Resources functions which need to be contemporary and fit-for-purpose for the workforces. While this is a significant shift for many workplaces it should not come at the cost of valuable Lived Experience (Peer) expertise or add to the invisible **emotional labour**<sup>11</sup> already inherent in the work. This labour takes a toll on those bringing their lived experience into the workplace.

A cultural element of emotional labour could be present for First Nations workers who are embedded in and accountable to their community and who may often need to assist family and community members as part of cultural obligation. This means they may not often have the opportunity to switch off. This example invites us all to reflect on where the emotional

labour sits in our domain and what organisational strategies need to be employed to minimise its impact.

The Peer Workforce Report<sup>xxix</sup> outlines the psychosocial health and safety risks that Lived Experience (Peer) workers may be exposed to in workplaces including:

- 42% dissatisfied with levels of stigma and discrimination in the workplace, a majority had taken sick leave for work-related reasons
- One in five had resigned for work-related reasons.

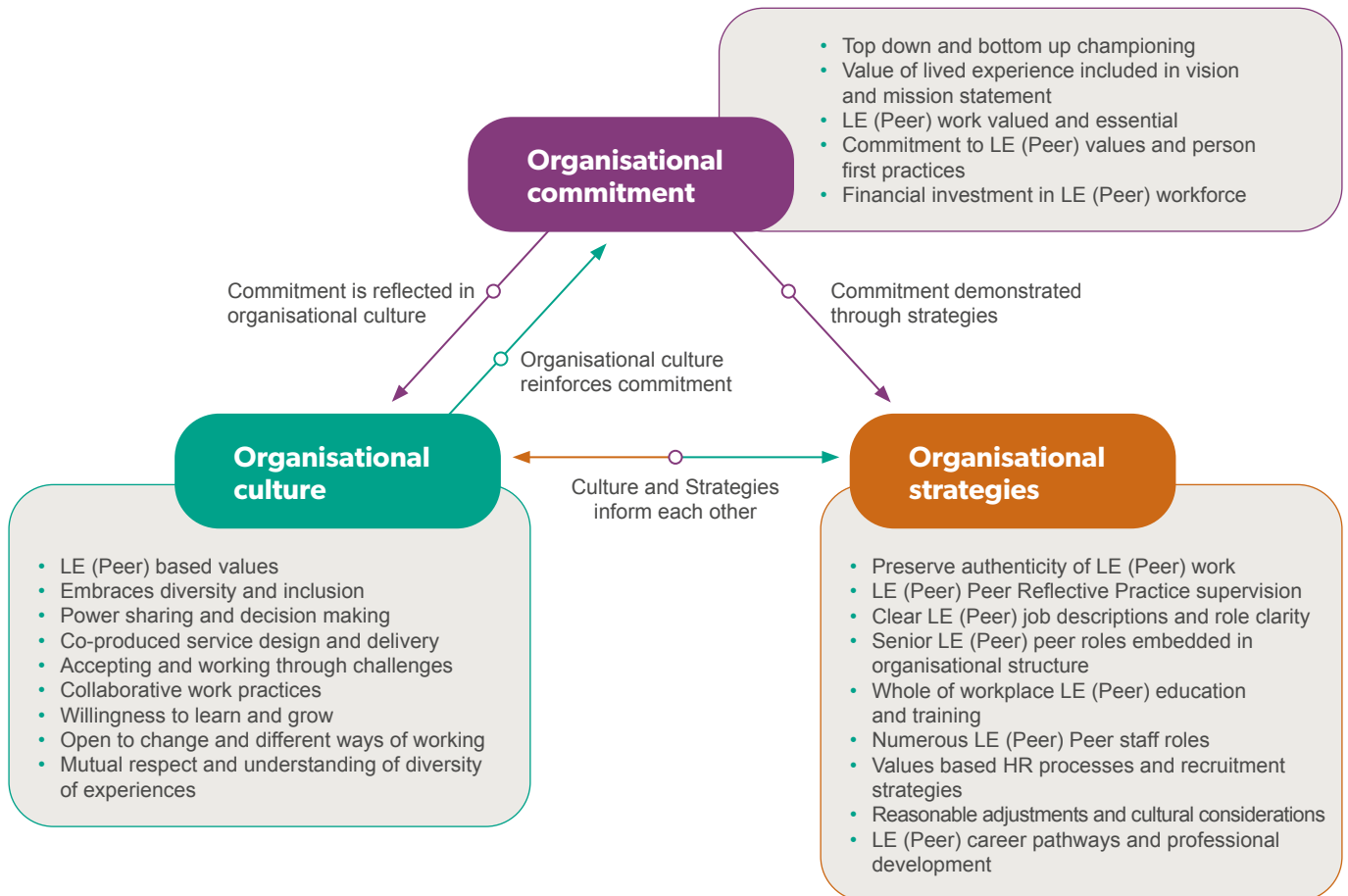
In summary, the onus of embedding a Lived Experience (Peer) Workforces cannot and should not rest with the Lived Experience (Peer) Workforces. It is a whole of organisational action requiring allies and champions from executive leadership through management to operational staff. This approach requires overarching focus on key elements of the organisation including commitment, culture and strategies.

<sup>10</sup> Identified during the Aboriginal Workforce consultations in the development of this Framework.

<sup>11</sup> Emotional labour is the process of managing feelings and expressions to fulfil the emotional requirements of a job.' (Hochschild, 1983, p.7)



Figure 12<sup>xl</sup> below seeks to convey a range of actions which organisations can employ and embed in order to provide safe working places for Lived Experience (Peer) Workforces and from which other workforces will also benefit.



## Starting the conversation in your organisation

Organisations, whether already having designated Lived Experience (Peer) worker roles, or just beginning the journey of capacity building and embedding Lived Experience (Peer) Workforces need to begin by starting the conversation. Discussions must include all levels of the organisation and must be actively and deliberately championed at an executive level. Being curious about the idea of developing or expanding the Lived Experience (Peer) Workforce is a great place to start. There is a range of resources already available to assist which are detailed in the supporting document and on the webpage.

### Questions to consider include:

- What is the overall aim of the Lived Experience (Peer) Workforce planning project?
- Who needs to be in the room to co-design this whole-of-organisation strategy?
- What does our organisation aim to achieve by developing Lived Experience (Peer) Workforces?
- What might change in our organisation and what might we need to unlearn and let go of in order to make this change effective?
- What resources – financial, people, technology – is our organisation committing to this?
- What are the measurable milestones and what is our timeline for different parts of the project?
- What new ways of being and learning might come about for our organisation which will serve to improve our overall performance?



## Embedding Lived Experience (Peer) Work as an essential part of service delivery

The Lived Experience (Peer) Workforce provides an opportunity to help all stakeholders understand through the lens of lived experience to achieve better outcomes for the individuals, their families, supporters and the wider community. Workforce development is not simply about creating new jobs; it is about the internal organisational and individual professional development that shifts the focus to the experience of mental illness<sup>xii</sup> and problematic alcohol and other drug use.

In embedding Lived Experience (Peer) Workforces, organisational and professional development that shifts the focus from diagnosis to the experience of mental illness and problematic alcohol and other drug use is essential. Workforce development is not simply creating new roles but creating opportunities for these new roles and the system they work within, to thrive.

International, national and state workforce studies<sup>xiii</sup> identify the following elements are required to build and sustain thriving Lived Experience (Peer) Workforces:

- Lived Experience (Peer) Workforces Principles
- Role Clarification – including designated specialist and leadership roles
- Organisational Development– including identifying barriers and enablers
- Training – including accredited and non-accredited options
- Professional Development and Supervision – nuanced to the Lived Experience (Peer) Workforces
- Career Pathways and Progression – including Lived Experience (Peer) leadership roles

**“ It is essential that mental health, alcohol and other drug services work together across primary care, community and hospital-based services and across health and human service sectors in an integrated, coordinated way to improve consumer, family and carer service experience and outcomes.”**

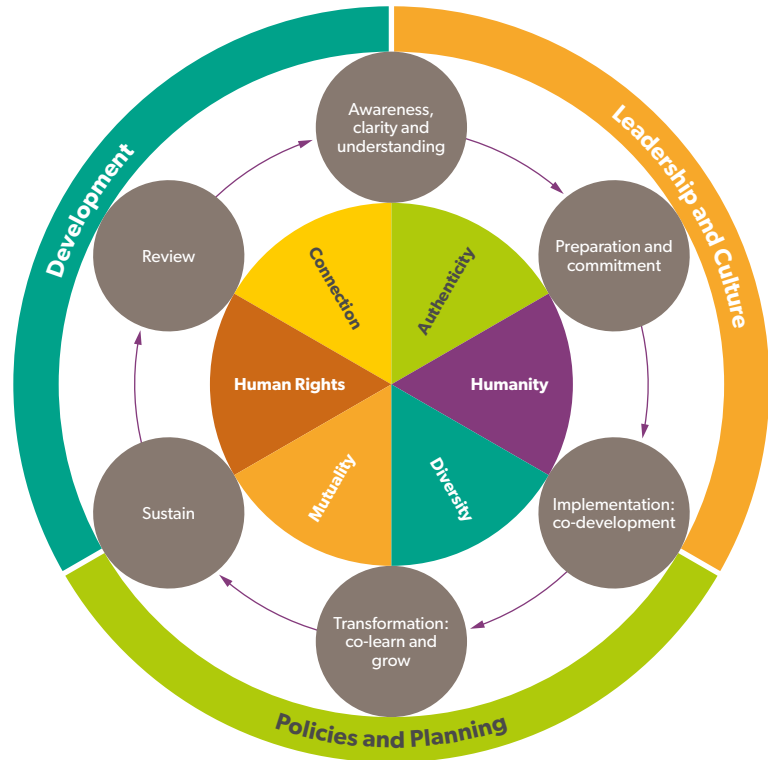
– The Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025, p. 152



These elements were also endorsed through stakeholder workshops as vital, if real reform in the mental health, alcohol and other drug and suicide prevention sectors that include Lived Experience (Peer) Workforces is to be realised.

Figure 13 on the right was synthesised from feedback received through the WA Lived Experience (Peer) Workforce Project consultations. It reflects the embedding of Lived Experience (Peer) principles in the centre of the system with key components and levers for organisational development.

**Figure 13: Principles and components of Lived Experience (Peer) work and levers for organisational development.**



**Whole of service foundation training needs to be facilitated to ensure that staff and stakeholders appreciate the value and understand the roles of Lived Experience (Peer) Workforces, and specifically how their work practices may need to change to support these workforces.**

Cultivating and sustaining Lived Experience (Peer) Workforces across mental health, alcohol and other drug and suicide prevention sectors is vital if system transformation is to be achieved. Embedding Lived Experience (Peer) workers in current systems and models as an 'add on' will result in more of the same limited outcomes. What is required is the understanding of new ways of being, doing and working that involves co-production

in all its forms and at every stage. As per Figure 12, the implementation and embedding of the Lived Experience (Peer) Workforces requires progression through the cycle of Awareness clarity and understanding; Preparation and commitment; Co-developed Implementation; Co-learn and grow; Sustain; and Review to evolve.

To support this cycle, organisations need to reflect and review leadership and culture, policies and planning and overall organisational development for a Lived Experience (Peer) embedded thriving service system.

Detailed information about the elements, components, levers (that is, the stages of organisational development) and how to implement them can be found in the supporting resources on the Lived Experience (Peer) Workforces website.



# Recommended actions

Throughout the development of this Framework, the following actions were identified as central to ensuring the Western Australian Lived Experience (Peer) Workforces are diverse and sustainable into the future.<sup>12</sup> The responsibility of these actions are shared between the system lead and local organisations and service providers.

## Mental Health Commission

### Actions:

1. **Commission rigorous lived experience co-led research to accurately map the current status of the Lived Experience (Peer) workforce across the state-wide Mental Health Alcohol and Other Drug, and Suicide Prevention sectors.** This research will:
  - i. Investigate and map the current Lived Experience (Peer) Workforces settings and roles
  - ii. Develop standardised tools for benchmarking according to Lived Experience (Peer) Workforces quality criteria
  - iii. Undertake a gap analysis
  - iv. Identify the number, levels, descriptors of Lived Experience (Peer) workers required across the Lived Experience (Peer) Workforces to be effective and sustainable.
2. **Commission the establishment of a Lived Experience (Peer) Workforces association to support and represent the growing Lived Experience (Peer) workforce.** This will involve:
  - i. Working with the Lived Experience (Peer) Workforces leadership and other relevant stakeholders to establish a constitution and objectives according to Lived Experience (Peer) governance systems, values and protocols.
3. **Invest in and develop a state-wide Lived Experience (Peer) Workforces infrastructure across the mental health, alcohol and other drug and suicide prevention sectors, assisting organisations to develop Lived Experience (Peer) Workforces.** This is inclusive of the development of:
  - i. A Lived Experience (Peer) Governance structure (to ensure fidelity to Lived Experience (Peer) Workforce values and body of knowledge)
  - ii. A Lived Experience Workforce Strategy template
  - iii. A whole of organisation readiness toolkit
  - iv. Relevant training packages (alternative and accessible, accredited and non-accredited training for Lived Experience (Peer) workers) based on Lived Experience (Peer) workforces, principles, practices and disciplines.
  - v. State-wide Lived Experience (Peer) supervision mechanisms to ensure the whole Lived Experience (Peer) workforce can access relevant, skilled Lived Experience (Peer) supervision, networking and professional development.
  - vi. Establish quality Lived Experience (Peer) Reflective Practice Supervision (*inclusive of* training and standards for Lived Experience (Peer) Reflective Practice Supervision).
  - vii. Lived Experience (Peer) Workforces Values-Based Recruitment Package.
  - viii. Relevant WA Lived Experience (Peer) Workforces Framework supplementary documentation (*inclusive of* a website).
  - ix. Contemporary and equitable remuneration awards (partnering with relevant agencies).
  - x. High level, contemporary Lived Experience leadership programs and initiatives congruent with Lived Experience (Peer) Workforces skills, knowledge, values and practices.

<sup>12</sup> Further details about these recommendations will be available on the Lived Experience (Peer) Workforces website in due course.





## Organisations and service providers

### Actions:

#### 1. Invest in and develop an organisation wide *Lived Experience Workforces Strategy*

- a. Boards, Executives and Senior staff demonstrate leadership in this area by recruiting *Lived Experience Governance Advisors* to co-lead the development of an organisation wide Lived Experience Workforce Strategy
- b. This strategy will outline the training and development program for all areas of the organisation to become Lived Experience (Peer) Workforce ready (including HR, Executive & Management, Finance, Training Departments etc). This strategy will also:
  - i. Clearly outline the KPIs and timelines that organisations will action to ensure a *Lived Experience Governance System*,<sup>13</sup> which guides the implementation, growth and sustainability of diverse Lived Experience (Peer) Workforces. This includes, but is not limited to, addressing the disparity of family/carer roles across Aboriginal, alcohol and other drug and mental health Lived Experience (Peer) Workforces.
  - ii. Outline the whole of organisation Training & Development pathways to understand and work alongside the Lived Experience (Peer) Workforces.
  - iii. Build in a review and evaluation component that reviews and evaluates progress to ensure fidelity with Lived Experience Governance systems, values and protocols.
  - iv. Work with relevant external authorities and internal managers to identify and establish clear career pathways to develop contemporary and equitable remuneration awards.
  - v. Develop a Lived Experience (Peer) supervision framework (modelled off the state-wide one which is under development) to ensure the whole Lived Experience (Peer) workforce can access relevant, skilled Lived Experience (Peer) supervision, networking and professional development.
  - vi. Establish high level, contemporary Lived Experience leadership programs and initiatives congruent with Lived Experience (Peer) Workforces skills, knowledge, values and practices.

<sup>13</sup> A LE Governance System will ensure that LE Peer values are at the heart of the work and will ensure fidelity to the Lived Experience body of knowledge (human rights and social justice mission) is front and centre in its development.







## Endnotes

- <sup>i</sup> Transforming Indigenous Mental Health and Wellbeing (2021) Fact Sheet: Social and Emotional Wellbeing – [timhwb.org.au/wp-content/uploads/2021/04/SEWB-fact-sheet.pdf](https://timhwb.org.au/wp-content/uploads/2021/04/SEWB-fact-sheet.pdf)
- <sup>ii</sup> Aboriginal Health Council of Western Australia (2021) ACCHS Social & Emotional Wellbeing Service Model
- <sup>iii</sup> Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025.
- <sup>iv</sup> Davidson, L. and Guy, K., 2012. Peer support among persons with severe mental illnesses: a review of evidence and experience. *World psychiatry*, 11(2), pp.123-128.
- <sup>v</sup> Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. and Whitley, R., 2014. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*, 13(1), pp.12-20
- <sup>vi</sup> UN Special Rapporteur, Püras D., 2020. The world must change the way mental health challenges are addressed, UN expert says: [www.ohchr.org/en/press-releases/2020/07/world-must-change-way-mental-health-challenges-are-addressed-un-expert-says](https://www.ohchr.org/en/press-releases/2020/07/world-must-change-way-mental-health-challenges-are-addressed-un-expert-says)
- <sup>vii</sup> O'Neill, J., Tabish, H., Welch, V., Petticrew, M., Pottie, K., Clarke, M., Evans, T., Pardo, J.P., Waters, E., White, H. and Tugwell, P., 2014. Applying an equity lens to interventions: using PROGRESS ensures consideration of socially stratifying factors to illuminate inequities in health. *Journal of clinical epidemiology*, 67(1), pp.56-64.
- <sup>viii</sup> Farre, A. and Rapley, T., 2017, November. The new old (and old new) medical model: four decades navigating the biomedical and psychosocial understandings of health and illness. In *Healthcare* (Vol. 5, No. 4, p. 88). MDPI.
- <sup>ix</sup> Johnstone, L., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D. and Read, J., 2018. The power threat meaning framework: Overview. Leicester: British Psychological Society.
- <sup>x</sup> Neitzke, A.B., 2016. An illness of power: gender and the social causes of depression. *Culture, medicine, and psychiatry*, 40(1), pp.59-73
- <sup>xi</sup> Aboriginal and Torres Strait Islander Lived Experience Centre – [www.blackdoginstitute.org.au/education-services/aboriginal-and-torres-strait-islander-network](https://www.blackdoginstitute.org.au/education-services/aboriginal-and-torres-strait-islander-network) or Self Help Addiction Resource Centre (SHARC) [www.sharc.org.au/sharc-programs/peer-projects](https://www.sharc.org.au/sharc-programs/peer-projects)
- <sup>xii</sup> Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. National Lived Experience Workforce Guidelines. 2021, National Mental Health Commission. page 4
- <sup>xiii</sup> Rhys Price-Robertson, Angela Obradovic & Brad Morgan (2017) Relational recovery: beyond individualism in the recovery approach, *Advances in Mental Health*, 15:2, 108-120, DOI: 10.1080/18387357.2016.1243014
- <sup>xiv</sup> Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews – *The Lancet Psychiatry* (2018). – [www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(18\)30060-9/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30060-9/fulltext)
- <sup>xv</sup> WA whole-of-sector Outcomes Framework – [www.wacoss.org.au/library/outcomes-measurement-framework-resources](https://www.wacoss.org.au/library/outcomes-measurement-framework-resources)
- <sup>xvi</sup> (Byrne, L., et al., 2021) page 20
- <sup>xvii</sup> Gee, G., Dudgeon, P., Schultz, C., Hart, A., & Kelly, K. (2014). Aboriginal and Torres Strait Islander social and emotional wellbeing. *Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice*, 2, 55-68
- <sup>xviii</sup> Transforming Indigenous Mental Health and Wellbeing (2021) Fact Sheet: Social and Emotional Wellbeing – [timhwb.org.au/wp-content/uploads/2021/04/SEWB-fact-sheet.pdf](https://timhwb.org.au/wp-content/uploads/2021/04/SEWB-fact-sheet.pdf)
- <sup>xx</sup> Aboriginal and Torres Strait Islander Lived Experience Centre, Black Dog Institute. (2020). Lived experience definition released for Aboriginal and Torres Strait Islander communities. [www.blackdoginstitute.org.au/media-releases/lived-experience-definition-released-for-aboriginal-and-torres-strait-islander-communities](https://www.blackdoginstitute.org.au/media-releases/lived-experience-definition-released-for-aboriginal-and-torres-strait-islander-communities)
- <sup>xxi</sup> Wungening Aboriginal Corporation (2019) Wungening and WAPHA AOD Workforce Capacity Building Project 2018-2019
- <sup>xxii</sup> Adapted from (Byrne, L., et al., 2020) page 13
- <sup>xxiii</sup> (Byrne, L., et al., 2021) page 25
- <sup>xxiv</sup> Byrne, Louise. & Queensland Mental Health Commission, issuing body. (2017). *Promoting lived experience perspective : discussion paper*. [Brisbane] : [Queensland Mental Health Commission], [www.qmhc.qld.gov.au/about/publications/browse/discussion-papers/promoting-lived-experience-perspective-discussion-paper](https://www.qmhc.qld.gov.au/about/publications/browse/discussion-papers/promoting-lived-experience-perspective-discussion-paper)
- <sup>xxv</sup> Guidance on Community Mental Health Services, pp 70-85
- <sup>xxvi</sup> Adapted from the WA Peer Supporters' Network. 2018. The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services. [www.comhwa.org.au/wapsn](https://www.comhwa.org.au/wapsn)
- <sup>xxvii</sup> Trachtenberg M, Parsonage M, Shepherd G et al (2013) Peer support in mental health care: Is it good value for money? Centre for Mental Health (PDF) – [www.centreformentalhealth.org.uk/sites/default/files/2018-09/peer\\_support\\_value\\_for\\_money\\_2013.pdf](https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/peer_support_value_for_money_2013.pdf)
- <sup>xxviii</sup> Lawn, S., A. Smith & K. Hunter. 2008. Mental Health Peer Support for Hospital Avoidance and Early Discharge: An Australian Example of a Consumer Driven and Operated Service. *Journal of Mental Health*. 17(5): 498-508.
- <sup>xxix</sup> Employee Guide to Implementing a Peer Workforce. NSW Mental Health Commission. (Lawn et al 2008).
- <sup>xxx</sup> WA Mental Health Commission Annual report 2020-2021.
- <sup>xxxi</sup> Mental health services in Australia: Specialised mental health care facilities 2019 -20. Australian Institute of Health and Welfare. [www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-facilities](https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/specialised-facilities)
- <sup>xxxii</sup> Hancock, N., Scanlan, J.N., Banfield, M., Berry, B., Pike-Rowney, G., Salisbury, A. & Norris, S. (2021). Independent Evaluation of NSW Peer Supported Transfer of Care initiative (Peer-STOC): Final report. The University of Sydney & Australian National University, Australia. [www.health.nsw.gov.au/mentalhealth/professionals/Pages/peer-supported-transfer-of-care.aspx](https://www.health.nsw.gov.au/mentalhealth/professionals/Pages/peer-supported-transfer-of-care.aspx)
- <sup>xxxiii</sup> Skinner, N., McEntee, A. & Roche, A. (2020). Australia's Alcohol and Other Drug Workforce: National Survey Results 2019-2020. Adelaide, South Australia: National Centre for Education and Training on Addiction (NCETA), Flinders University. [nceta.flinders.edu.au/workforce/alcohol-other-drugs-national-workforce-survey](https://nceta.flinders.edu.au/workforce/alcohol-other-drugs-national-workforce-survey)
- <sup>xxxiv</sup> Ibid
- <sup>xxxv</sup> The Australian Government (2020). Closing the Gap in Partnership. *National Agreement on Closing the Gap 2020*. [www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap](https://www.closingthegap.gov.au/national-agreement/national-agreement-closing-the-gap)
- <sup>xxxvi</sup> World Health Organisation. (1978). Declaration of Alma-Ata. Retrieved May 6, from [www.who.int/publications/almata\\_declaration\\_en.pdf](https://www.who.int/publications/almata_declaration_en.pdf)
- <sup>xxxviii</sup> Byrne, L. (2014). A grounded theory study of lived experience mental health practitioners within the wider workforce. Unpublished doctoral thesis. Central Queensland University, Rockhampton, Australia.
- <sup>xxxix</sup> (WA Peer Supporters' Network. 2018) Page 8
- <sup>xl</sup> Adapted from Louise Byrne, Chyrell Bellamy, Helena Roennfeldt, Jessica Wolf, Ally Linfoot, Dana Foglesong, and Larry Davidson. Effective Peer Employment Within Multidisciplinary Organizations: Model for Best Practice. August 2021, p. 12. Readiness and Change
- <sup>xli</sup> (Byrne, L., et al., 2021) page 4
- <sup>xlii</sup> A Peer Work Strategic Framework for the Mental Health and Alcohol and Other Drug Sectors in WA. WAAMH. 2014





**The inclusion of a Lived Experience (Peer) Workforce at all levels is now the expectation not the exception.**

– WA Lived Experience (Peer) Working Group







Government of Western Australia  
Mental Health Commission

**“ Lived Experience Peer  
Workers are the evidence  
recovery is real.”**

– Patricia Deegan



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