Our Future

Developing introductory training for the lived and living experience workforces in Victoria.

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Acknowledgements

Acknowledgement of Country

The Our Future partnership acknowledges this project has been carried out on Aboriginal country throughout Victoria and we acknowledge the traditional custodians of the land, respecting their continuing connections to land, sea, and community.

We pay our respects to their Elders, both past, present and emerging.

This project relates to mental health and addictions, and we particularly acknowledge the lived and living experiences of Aboriginal and Torres Strait Islander in their personal and collective journeys. This includes the inequitable treatment that Aboriginal and Torres Strait Islanders have received, and continue to receive, by health and related services and a valuing of their perspectives on social and emotional well-being.

Contributors and stakeholders

We would like to thank the following people and organisations for their support and contributions to this project:

- Members of the lived and living experience workforces (LLEWs) for sharing their experiences and insights through the survey and focus group discussions.
- Our secondary project partners, the Victorian Mental Illness Awareness Council (VMIAC), Tandem, and the Satellite Foundation for their assistance to engage the lived and living experience workforces to ensure the recommendations in this report were informed by, are reflective of and responsive to the specific needs of the LLE workforces.
- The Department of Health for recognising the importance of investing in LLE-led solutions through commissioning an LLE-led partnership approach at the early stages of developing introductory training for the LLE workforces - a vital step towards further embedding LLE workforces in the mental health and AOD systems.

Conflict of Interest

This project has been conducted by a collection of partners, the majority of whom are both Lived and Living Experience Training subject matter experts and providers of Lived and Living Experience Training.

This raises the possibility of potential or perceived conflict of interest.

This is a common situation in the public sector. As David Burfoot, Senior Advisor to The Ethics Centre, writes for the Independent Broad-based Anti-corruption Commission:

> *"You can't be good – or even bad – at your job these days without having a host of professional and personal relationships which, at times, mix. So it is common for public officials, or any experts, to find themselves in situations in which their personal relationships intersect with their professional ones."*[1]

Any action arising from this report needs to consider the potential or perceived conflict of interest that might arise, for example, in commissioning further work or purchasing training.

Background and Team

The Project

The project partnership, with the Self Help Addiction Resource Centre (SHARC) as the lead agency, was commissioned by Mental Health Reform Victoria (MHRV) to conduct research and consultation to inform the development of recommendations for an introductory training package(s) for the Lived and Living Experience Workforces (LLEWs) in the Mental Health and Alcohol and Other Drug (AOD) sectors in Victoria.

This project was commissioned in response to Recommendation 6[2] of the interim report of the Royal Commission into Victoria's Mental Health System which identified an "inconsistent approach to training and learning and development in lived experience workforces." In response, the Royal Commission recommended that "all lived experience workers should have access to a minimum, standardised level of lived experience training" and that for all lived experience roles, "training in lived experience work should build on best practice models and be tailored to the Victorian context"(op cit).

This project is the first step in developing and delivering on this crucial recommendation for the rapidly growing LLE workforces. LLE-led introductory training will ensure that the full spectrum of lived and living experience workforces have access to relevant, best practice training to support them in their vital roles in the mental health and wellbeing, and alcohol and other drug systems.

The Partnership

This project was delivered by the Our Future partnership - four Victorian lived experience-led organisations and two organisations engaged with LLE workforces - totalling over 100 years of experience in the Mental Health and AOD Lived and Living Experience Workforces. These organisations have been formative in the history and trajectory of the LLE workforces, training and providing support to hundreds of lived and living experience workers in Victoria.

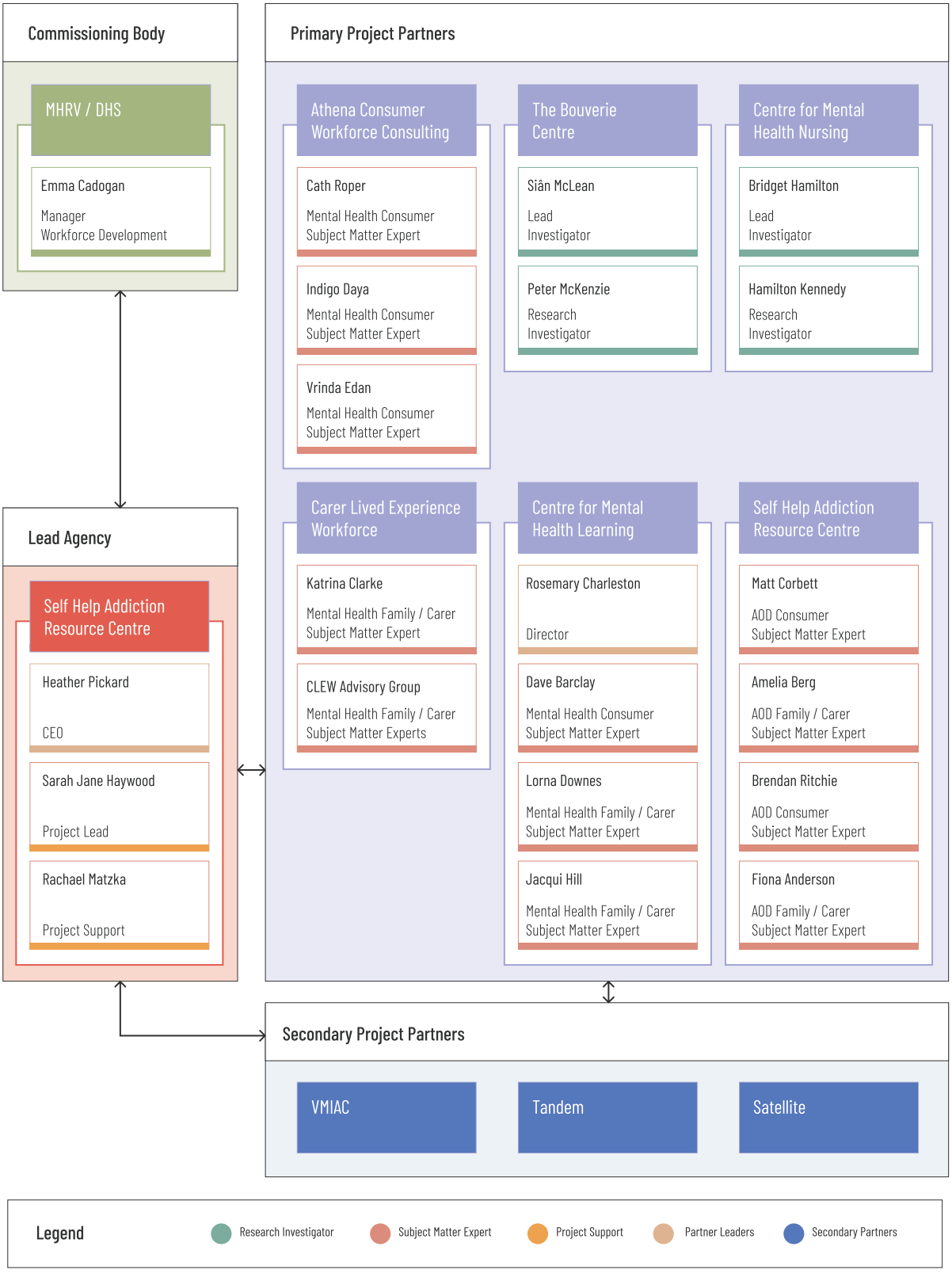
This project is led by SHARC, and is a partnership between:

- Athena Consumer Workforce Consulting (Athena)
- Centre for Mental Health Learning (CMHL)
- Centre for Mental Health Nursing (CMHN), University of Melbourne
- Carer Lived Experience Workforce (CLEW)
- Self Help Addiction Resource Centre (SHARC)
- The Bouverie Centre, La Trobe University

This project was also supported by the Victorian Mental Illness Awareness Council (VMIAC), Tandem and the Satellite Foundation.

From the outset, the partnership's vision for workforce training is for a comprehensive and customised approach. This means, working towards a future system in which all LLE workforces receive relevant, tailored training within a system that supports their growth and development.

Partnership Map



Project Components

Literature review

A literature review, conducted by The Bouverie Centre at La Trobe University, aimed to identify and review published literature on training for LLE workforces. Literature that examined empirical findings, either qualitative or quantitative, relating to provision of training was identified for inclusion. The literature review addressed two research questions:

1. What are the content areas and teaching and learning methods used in training programs? and
2. What are the outcomes for trainees from participating in workforce training?

Full analysis of the literature review findings is provided in Appendix 2.

Desktop audit of currently available trainings

A desktop audit of training currently available to the LLE workforces. This audit was conducted by The Centre for Mental Health Nursing at The University of Melbourne. A desktop audit is a high-level review of all available information on a topic to identify strengths, gaps and opportunities. This audit identified all known and available training for the Victorian workforces.

The audit was conducted by consulting expert researchers involved in the project, contacting experts in the field, investigating known training providers and by conducting Internet searches in order to identify training. It collated available information about these trainings such as: how they were developed and delivered, cost, and length. This audit was then refined by identifying major training providers or commonly completed training. This identified 60 trainings from 29 providers.

The training program data was then analysed in light of the project recommendations about development, delivery, content and access. These recommendations were used as quality markers with which to appraise the known training offerings, based on available data. This analysis is tabled in Part E of the report as the results of the desktop audit. The full and complete data from the desktop audit is provided in Appendix 3.

Survey of Lived/Living Experience Workforces

A survey of the LLEWs was conducted in collaboration between the partnerships' Subject Matter Experts - comprising partners across Athena, CLEW, CMHL and SHARC, all with extensive expertise in LLE workforce development and training.

The survey was co-developed by project partners and contained both quantitative and qualitative questions. Data was collected from people from the lived and living experience workforces. Following preparatory data cleaning and screening, each workforce group separately analysed findings from their respective cohorts:

- Mental Health Consumer workforce data analysed by CMHL and Athena
- AOD Consumer workforce data analysed by SHARC
- Mental Health Family/Carer workforce data analysed by CMHL and CLEW
- AOD Family/Carer workforce data analysed by SHARC

Full reporting of the analysis of survey results by the partner organisations is provided in Appendices 4-7. A full list of survey questions is available in Appendix 1.

Focus groups with LLE workforces

Core questions for focus groups were co-developed by the partnerships' Subject Matter Experts and focussed on the training needs of those beginning in LLE roles.

Each workforce cohort conducted separate focus groups with their cohort groups and synthesised the data using thematic analysis.

Full reporting of the analysis of focus group findings by the partner organisations is provided in Appendix 4-7. Further information on focus group questions is available in Appendix 1.

Key Milestones of the LLE Workforces

The four LLE workforces engaged as part of this project are workforces that have developed separately through decades of activism and advocacy and, as such, have distinct approaches, values, perspectives and disciplines.

Of course, any attempt to write history or identify milestones risks leaving out key people and events that helped grow the workforces; the following points are meant to paint a general picture of the development of the workforces and we are always open to new inclusions and revisions.

Mental Health Consumer Workforce: A History

1960s - 90s

Deinstitutionalisation and early activism in Victoria

1960s-70s Closure of large mental hospitals and first consumer organisation, Australia Campaign Against Psychiatric Injustice and Coercion (CAPIC), established

1960s-70s A range of small consumer groups are established and supported by small community organisations and the university sector

1981 Establishment of the VMIAC, who advocated for mental health consumers' rights

1993 National Burdekin Report released finding widespread discrimination against consumers and stating they should be actively involved in decision-making

1996 - 2004

First consumer roles emerge

1995 VMIAC's *The Lemon Tree Learning Project* is the first project to explore ways consumers can train mental health clinicians

1996 First four Consumer Consultants are hired at the Royal Melbourne Hospital. Funding was made recurrent from 1998.

2000 First Consumer Academic position created at the University of Melbourne

2002 First consumer executive position created starting at 2hrs a month and growing to a 0.6 EFT role in 2003

2002 - 2011

Early establishment of workforce development infrastructure

2002-3 Earliest training programs delivered by Consumer Academic in partnership with VMIAC: *Strange Agents in a Strange Land*

2005 Consumer workforce added to Australian Services Union

2007 Consumer workers employed in the Personal Helpers and Mentors Scheme (PHaMS) funded by the Victorian Government

2010 'Consumer Perspective' first defined as a discipline by Merinda Epstein

2011 Centre for Excellence in Peer Support (CEPS) founded as resource for consumer workers

2012 - 2013

Consumer workforce in mainstream services

2012 First consumer peer support workers employed in clinical bed-based services in Melbourne

2013 First PeerZone facilitator training in Melbourne with workshops following

2013 First Certificate IV in Mental Health Peer Work developed

2015 - 2016

Rapid expansion of the peer workforce

2015 Victoria's 10-year plan proposes growing the lived experience workforces

2016-present Victorian Government funds the Expanding Post Discharge Support program - the first state-wide program to employ peer support workers in all inpatient settings across Victoria, leading to massive growth in the consumer workforce. Intentional Peer Support training is funded for peer workers in this program.

2016 First Statewide Consumer Workforce Development Officer employed at St Vincent's Hospital

2019 - 2021

Building the workforce to meet reforms

2019 Mental Health Consumer Workforce Strategy released - this is the first workforce strategy that is co-produced with the Consumer Workforce.

2019 Victorian Government funds six Prevention and Recovery Care Services (PARCS) to employ consumer peer support workers

2019 Now 359 consumer positions (192 Full-Time Equivalent roles) in Victoria[3]

2020 Consumer Perspective workforce supervision database developed by CMHL

2020 Lived Experience Workforce Advisory Group (LEWAG) established to provide advice to government on reforms and initiatives related to the LLE workforces across mental health, AOD treatment and harm reduction.

2021 Royal Commission into Victoria's Mental Health System recommends peer support as a core part of the new community model, and consumer leaders be embedded in key system governance structures

AOD Lived and Living Consumer Workforce: A History

1960s - 80s

Peer-led grassroots responses to addiction and AIDS emerge

1980s Alcoholics Anonymous – non-professional self-help groups – become biggest peer support movement in the world

1980s Estimated 70% of the workforce are people recovering from substance use disorders

1980s VIVAIDS (now known as Harm Reduction Victoria (HRVic)) founded in response to the HIV/AIDS crisis

1980s - 90s

Harm Reduction Victoria establishes first funded peer-led programs

1987 Harm Reduction Victoria (HRVic) funded by the Victorian Government after being formed earlier in the 1980s response to HIV/AIDS

1996-97 HRVic funded for several peer led projects into sex work, Hepatitis C and RaveSafe, as well as the Young Injectors Peer Education and Advocacy Project

2000 - 2011

Consumer participation emerges in policy and practice

Late-1990s Consumer participation begins to appear in key governmental policy documents

2000 Association of Participating Service Users (APSU at SHARC) established and funded by Department of Health to increase consumer participation in AOD

2001 Service and advocacy funding switched to Primary Health Care Units (e.g. Needle and Syringe Programs) staffed with LLE workers

2006 APSU developed first Peer Helper Training as introduction to LLE activities

2006-2008 Several key policy documents supporting consumer participation in AOD were released by the Victorian Government, including the *Doing it with us not for us: Strategic direction (2006)* which promoted consumer participation in all health services

2007 Uniting Vic (now known as Uniting Care ReGen) start developing consumer participation training for AOD to support consumers now participating in trying to shape the AOD sector

2007 APSU launched Peer Helper Training (now Lived Experience Applied (LEAP) training)

2011 *Strengthening Consumer Participation in the Victorian Alcohol and other Drug Sector* project delivered by APSU found that, in a decade's work, consumers were often only being involved in a consultative manner and not given opportunities for decision-making control and power

2012 - 2017

First paid roles and establishing training

2014 Peer Support Capacity Building Project by SHARC led to peer-led support groups (consumer and family) across Victoria with some agencies finding funding for Peer Leaders

2015 First funded AOD Peer Workers in Victoria after years of volunteer roles, with the exception of a part-time peer worker at Windana

2016-17 SHARC is key to developing workforce initiatives including the Peer Workforce Framework, a 5-day Peer Worker Training Program, Organisational Readiness Training along with discipline-specific Peer Worker Supervision

2018 - 2019

Consumer workforce emerging as a key part of the AOD system

2018 Government releases Victorian AOD Workforce Strategy, in which the AOD LLE workforces are mentioned extensively identifying further development, expansion, integration and support of the peer workforce as key to advancing the sector

2018 Peer Projects established at SHARC as central resource for AOD Peer Workforce Development

2017 Census shows 19 workers in AOD sector

2019 AOD Peer Workforce Strategy released - this is the first strategy that is developed by the LLE AOD workforce itself

2019 Now 56 positions (36 Full-Time Equivalent roles) in Victoria[4]

2019 - 2021

Expansion of workforce infrastructure as part of mental health reforms

2020 Lived Experience Workforce Advisory Group (LEWAG) established to provide advice to government on reforms and initiatives related to the LLE workforces across mental health, AOD treatment and harm reduction.

2021 Reducing Drug Harm Use Through Peer Led Networks extended and renamed Fuse Initiatives Project to develop framework, training, organisational readiness, supervision and support model

2021 As part of reforms from the Royal Commission into Victoria's Mental Health System, a new AOD Lived/Living Experience role is created in the Department of Health to embed LLE perspectives as well as the AOD LLEAG advisory group as a voice to government

Mental Health Family/Carer Workforce: A History

1970s - 90s

Early activism, networking and recognition of the needs of carers from government

1970s-80s Early community organisations and networks are built to support carers and advocate, including the Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI) formed in Victoria (1979)

1993 Organisations that support carers build networks to advocate. Victorian Mental Health Carers Network starts with support from Carers Victoria, the Schizophrenia Fellowship (now Wellways), SANE and ARAFEMI (now MIND)

1995 First family education courses developed by a family member were created, *Schizophrenia: teaching relatives the 14 principles of coping*

1996 Carers in the general public start formally being incorporated into strategies by the Victorian Government through the first Victorian carer strategy; *Victoria's Carer Initiatives Strengthening the Partnership*

1999 - 2005

First paid roles and participation efforts in services emerge

1999 First two carer peer support roles created through the Carers Offering Peers Early Support (COPES) program at Maroondah hospital and EACH community services

1999 St Vincent's establishes a Family and Carer Participation Committee

2000 First two Carer Consultant roles created at St Vincent's Hospital

2001 First Carer Consultant Network of Victoria established to support the small workforce, went on to become Carer Lived Experience Workforce (CLEW), now with 138 members

2002 Department of Health allocates funds to employ Carer Consultants in public mental health services in Victoria

2005 First Carer Academic position employed at the Bouverie Centre

2005 - 2012

Carer networks grow and some gains in paid roles

2005 First Carer Conference was held in Melbourne with 400 attendees

2007 National Register of Mental Health Consumers and Carers forms with 60 representatives to build national consumer and carer voice

2009 ARAFEMI Vic (now MIND) employs the first Carer Advocate in a pilot program. This role provides supportive counselling and advocacy to families, including attending tribunal hearings.

2009 Department of Health implements recurrent funding for Carer Consultant roles

2010 Victoria's 10-year mental health plan identifies the importance of growing the lived experience workforces, including carer workers

2012 Victoria passes the Carers Recognition Act which raises the profile of carers and their involvement in care

2012 - 2018

Expansion of Carer Peer Support roles and first carer workforce training

2012 First carer peer support worker employed in clinical bed-based services at Monash Health.

2012 Carer Consultants included in the Health and Community Services (HACSU) award.

2014 Tandem launched as the peak body representing family and friends supporting people living with mental health issues in Victoria

2016 DHHS funded Families where a Parent has a Mental Illness (FaPMI) coordinators in every area mental health service to support young carers

2016 First state-wide Carer Workforce Development Officer position created at St Vincent's Hospital

2017 First "Caring With, introduction to carer peer work" training delivered. This is the first accessible carer-designed and delivered training designed for the carer workforce.

2017 First Senior Carer Policy Officer employed by the Chief Psychiatrist

2018 Victorian Carer Strategy released, includes a key commitment to accessible carer peer support and community support programs

2019 - 2021

Major reforms to include carer workforce in mental health system

2019 Mental Health Family/Carer Workforce Strategy released. This is the first workforce strategy that is co-produced with the Family/Carer workforce.

2019 Now 98 carer positions (57 Full-Time Equivalent roles) in Victoria[5]

2020 Lived Experience Workforce Advisory Group (LEWAG) established to provide advice to government on reforms and initiatives related to the LLE workforces across mental health, AOD treatment and harm reduction.

2021 Royal Commission into Victoria's Mental Health System recommend eight family/carer led centres across Victoria, a state-wide peer call-back service for family/carers and family/carer roles in key governance positions

AOD Family/Carer Workforce: A History

1998 - 2010

First funding and emergence of peer-led family supports

1998 A group of family members, advocates, and members of the community come together to create a phone helpline for families. For its first two years of operation, it runs on a completely voluntarily basis.

2000 Family Drug Help (now known as Family Drug and Gambling Help) awarded funding from the state government to continue their work with support from SHARC. This includes a 24 hour helpline for families and significant others requiring support. Since this time, it has been staffed during normal working hours by family lived experience workforce.

2006 APSU develops first Peer Helper Training as introduction to LLE support which was attended by both family members and consumers.

2006 Family Drug Help (now known as Family Drug and Gambling Help) at SHARC employs one lived experience worker to coordinate Peer Support Groups for families across Victoria. This is the first paid AOD family/carer role after years of volunteer work and advocacy.

2014 - 2017

Expansion of LLE-led family peer support programs

2014 Peer Support Capacity Building Project by SHARC led to the development of peer-led support groups (consumer and family) across Victoria with some agencies finding funding for Peer Leaders

2017 - 2020

AOD Family/Carer workforce included and uplifted in broader LLE workforce strategies

2017 There are 34 lived experience volunteer family peer workers across the sector, supported by SHARC

2018 Government releases Victorian AOD Workforce Strategy, in which the AOD LLE workforces are mentioned extensively identifying the further development, expansion, integration and support of the peer workforce as key to advancing the sector

2018 Peer Projects established at SHARC as central resource for AOD peer workforce development

2020 Family Drug Help includes gambling and becomes Family Drug and Gambling Help

2020 - 2021

Expansion of workforce infrastructure as part of mental health reforms

2020 Lived Experience Workforce Advisory Group (LEWAG) established to provide advice to government on reforms and initiatives related to the LLE workforces across mental health, AOD treatment and harm reduction.

2021 As part of reforms from the Royal Commission into Victoria's Mental Health System, a new AOD Lived Experience Family/Carer role is created in the Department of Health to embed LLE perspectives. Alongside this the as well as the AOD Lived and Living Experience Advisory Group (AOD LLEAG) is established as a voice to government.

2021 There are now two family lived experience roles in Dual Diagnosis[6]

Glossary

The following acronyms and terms have been used in this report:

- AOD – Alcohol and Other Drugs
- CAG/CAGs – Consumer Advisory Group(s)
- CLEW – Carer Lived Experience Workforce; project partner.
- CMHL – Centre for Mental Health Learning; project partner.
- CMHN – Centre for Mental Health Nursing at the University of Melbourne; project partner.
- IPS – Intentional Peer Support training
- LLEWs – the Lived and Living Experience Workforces. This acronym is used to acknowledge that the AOD sector includes Harm Reduction or "living experience" workers, further information on terminology below.
- NSP – Needle and Syringe Program
- SHARC - the Self Help Addiction Resource Centre; project partner and lead agency for this project.
- VMIAC – Victorian Mental Illness Awareness Council; supporting partner.

A note on language

The project partnership would like to acknowledge the contested nature of several of the terms used in the mental health and AOD sectors, and explain the use of the following terms.

Lived and Living Experience Workforces (LLEWs)

This report uses the term 'lived experience' is used to refer to both:

- People with experience of emotional distress, trauma, mental health challenges, addiction, and drug use, as well as
- Their families, carers and supporters

The term 'living experience' is used in the Alcohol and Other Drug sector to refer to people with current experience of drug use and overdose risk who are employed in harm reduction roles that promote the health and wellbeing of people who use drugs.

In this report we refer to these four distinct workforces: mental health consumer workforce, AOD consumer workforce (which includes lived experience and living experience roles), mental health family/carer workforce, and AOD family/carer workforce.

For purposes of clarity, we have chosen to use the term (and acronym) Lived and Living Experience workers or workforces (LLE workers or LLEWs) throughout this report to refer to these workforces as a whole.

Consumer and Consumer Workforces

For this report, we have used the term 'consumer' to refer to people with experience of emotional distress, trauma, mental health challenges, addiction and drug use. We have used the term 'consumer workers' or 'consumer workforces' to describe workers who have, and intentionally work from, the perspective of direct lived experience of the mental health and AOD systems in which they work.

Consumer workforce roles are diverse, some common roles include: peer support, advocacy, advisor, consumer consultant, consumer academic, consumer perspective supervisor, consumer educator and roles in management and governance.

We acknowledge that consumer workers, and indeed all people who have experienced the mental health and AOD systems, have different preferences about the language used to describe and understand our lived and living experience. These preferences are grounded in life experiences which can be painful and deeply significant. While originally the term 'consumer' was chosen by our own lived experience community as being preferable to 'patient', it no longer has widespread support (The Declaration, VMIAC, 2019) and is often disputed.

Family

Family includes the consumer and those with a significant personal relationship with the consumer. This includes biological relatives and non-biological relatives, intimate partners, ex-partners, people in co-habitation, friends, those with kinship responsibilities, and others who play a significant role in the consumer's life. Some family members may identify themselves as a 'carer' in a consumer's life, others will identify more so with the characteristic of their relationship (for example; parent, child, partner, sibling). (Department of Health and Human Services, 2018, p. 5).

For people who have experienced familial rejection, neglect or abuse, recognition of their 'family of choice' is especially important.[7]

Carer

A carer is someone who is actively supporting, assisting or providing unpaid care to a consumer. A carer may, or may not, live with the consumer. A carer may be a family member, friend or other person, including someone under the age of 18 years, who has a significant role in the life of the consumer.[8]

Family/Carer workforce

Family/carer workforce is a collective term for workers in a range of roles providing support and connection for a consumer's family, some of whom may identify as a carer. This may directly through providing peer support, or indirectly through leadership, advocacy, education, and research. The authors of this document have chosen the terms 'family/carer worker' and 'family/carer workforce' as it is respectful of those who prefer to identify by their relationship rather than as a carer.[9]

Table of Contents

Executive Summary

In 2021, the Victorian Mental Health and AOD sectors face their most significant inflection point since deinstitutionalisation in the 1990s. This moment, and the outcomes of this project, present the opportunity to establish a vibrant service system with well trained, supported, and thriving LLE workforces at its core.

This is a vital moment to establish solid foundations, ways of working and to crystalise and safeguard the unique capabilities, contributions and perspectives the LLE workforces bring - something that is vitally needed for the long-term structural reforms ahead.

The workforces are: mental health consumer workforce, AOD lived and living experience workforce, the mental health family and carer workforce and the AOD family and carer workforce. Each workforce has a distinct history in Victoria and each arises from a specific source, whether linked to an international socio-political movement for change or emerging from a local advocacy movement. Through 50 years of growth since the earliest appointments in Victoria, the workforces have formed their own philosophical commitments, language and identities. While these lived experience workforces might share a change agenda, some objectives and, may at times, be positioned in allyship with each other, ***they are not the same.***

The project team gathered capable partner organisations and subject matter experts at the one table. The approach to the project was based on principles of co-design and brought together the relevant thought leadership to consult and design these recommendations.

Four research and consultation components collected data to inform the development of recommendations for introductory training for the four LLE workforces engaged in this project. These were:

- a desktop review of training available to the LLE workforces, with 60 programs from 29 providers reviewed,
- rapid literature review of published empirical literature which drew on 36

papers from an original screen of 2432 papers examining LLE workforces training

- survey of people in LLE workforce roles to examine perceptions of training experiences, with over 200 responses, and focus groups conducted with workforce cohorts to identify essential content to be included in LLE workforces training, with 96 participants from the workforces.

The data collection represents substantial investment from the target populations. Responses to the survey from 204 participants (MH Consumer *n* = 61; MH Family/Carer *n* = 52; AOD Consumer *n* = 55; AOD Family/Carer *n* = 23) were analysed and 15 focus groups with 96 participants (MH Consumer *n* = 29; MH Family/Carer *n* = 25; AOD Consumer *n* = 29; AOD Family/Carer *w* = 13) were conducted. Data was analysed by Subject Matter Experts in the corresponding LLE workforce.

All partners met 10 times over 5 months, with an additional 13 meetings between the Subject Matter Experts, including two workshops to refine recommendations. These collaborative opportunities ensured a robust investigation of the problem and potential solutions.

At each step of the process, including the development of the following recommendations, each workforce, through their input, confirmed the differing natures of their development, aspirations and needs. The recommendations have been written to reflect their differences and similarities.

Recommendations

The centrepiece of the report is a set of essential requirements for effective training of the LLE workforces, as seen by these workers and distilled into six specific recommendations across four themes.

These accord with themes of: Development and Delivery of Training, Essential Content for Training, Training Format and Accessibility of Training. The workforces themselves emphasised the essential nature of the structure and context in which training occurs and the settings in which trainees then apply their work. Therefore, this report includes adjacent recommendations in the themes of Context and Structure for Training, regarding organizational development and LLE workforce development, where such recommendations are essential for a program of LLEW training to achieve its goal of creating thriving LLE workforces.

Development and Delivery of Training

Recommendation #1

To ensure introductory training is relevant and best-practice for the LLE workforces,

1.1 Training is developed and delivered by the corresponding LLE workforce by those who have worked in that workforce and have training expertise.

1.2 The Department of Health delivers focussed investment in developing more workforce specialist educators to build capability for the development and delivery of training.

1.3 Training undergoes a process of continuous evaluation and improvement and requires a formal review process every 12 months with an understanding that, due to the establishing nature of these workforces, this is done to enable discipline development and ensure training upholds best-practice and maintains relevance.

Essential Content For Training

Recommendation #2

To ensure introductory training contains the essential core elements required by the workforces:

2.1. Introductory training for each of the four LLE workforces is developed in accordance with the content outlines developed by the different cohorts, provided in Figures 1-4, Part B of this report.

2.2 Content development is undertaken by the relevant cohorts.

Training Format

Recommendation #3

To ensure that training is developed and delivered in a format that is responsive to workforce needs:

3.1 Training is tailored to the demographic characteristics, work situation and development needs of the LLE workforces.

3.2 Training is available online and face-to-face.

3.3 Training is delivered with diverse learning approaches, i.e. hands on vs theoretical learning.

3.4 Training includes formative assessments that do not make training completion prohibitive.

Accessibility of Training

Recommendation #4

To ensure that all training is accessible to the workforces:

4.1 All workers have access to introductory workforce training within the first 12 months of employment.

4.2 All training is state-funded or, at a minimum, subsidised by the Department of Health.

4.3 The Department of Health mandates release during work hours for LLE workers to engage in training. Those workers working part-time, be given adequate paid study leave to complete their training.

In addition to this, we recommend that further work be undertaken by the Department to ensure that systems are in place to ensure policy levers, as well as accountability measures, are in place to ensure accessibility to any introductory training.

Organisational Supports

Recommendation #5

To ensure working environments for the LLEWs are safe and supportive for workers, the Department of Health resource the following strategies:

5.1 Organisations employing LLE workers undertake organisational readiness training to make certain that all (non-LLE) colleagues understand the nature of LLE work; the LLE workers' experience and knowledge base; and the skills required to work alongside the LLEW

5.2 LLE workers are provided with access to discipline-specific supervision, co-reflection, mentoring and networking with other LLE workers to ensure knowledge translation and contextualising learning to the workplace

5.3 Organisations encourage, resource and fund the professional development of the LLE workforces. This includes LLE apprenticeships, traineeships, line management, and supportive performance development opportunities to support early career pathways.

Essential development of LLE workforces

Recommendation #6

To ensure the sustainability and further establishment of the LLE workforces as professions, the Department of Health resource the following strategies:

6.1 Develop stewardship strategies to establish and sufficiently resource professional bodies to support, advocate and develop the LLE professions.

6.2 Investment in organisations that provide vital support functions for LLEW such as: advocacy and representation of the workforces, professional development, networking, mentoring, and community of practice.

6.3 Investment in LLE workforce-led research to build the LLEWs disciplinary perspectives, which are vital to developing training content.

6.4 Development of discipline-specific role descriptions for LLEWs to enable consistency across the workforces. Those designing role descriptions to have significant expertise of working in that role and expert knowledge of any theoretical and philosophical underpinnings of the relevant discipline.

6.5 The provision of genuine opportunities for career development, leadership opportunities and articulation into existing educational pathways, especially as the LLEWs rapidly grow. Partnerships with Universities and TAFES to achieve this goal to be explored.

6.6 As an interim measure in lieu of a specific professional body, LLE workers should have access to specialist LLE educators.

Conclusion

In addition to soundly framing these recommendations in the body of the report, this document includes, as four workforce-specific appendices, the rich analysis of the conversations and responses among the 300 responses from LLE workers. Some additional workforce specific recommendations were developed after the workshops and are included in the consultation reports in the appendices. The appended reports also include formative versions of learning objectives for introductory training for each of the LLEWs.

The potential of the LLEWs in the Victorian services is, as yet, unrealised. As the potential is recognised and worker numbers grow, effective and timely training is a fundamental development piece, urgently needed. If the recommendations in this report are not taken up, the sector risks insufficient workforce capacity; inadequately prepared workers; role drift and co-option into out-of-scope work; and developmental stagnation of the LLE workforces. Significantly, lack of action in following these recommendations risks not meeting the reform goals of the Royal Commission, which represent an unprecedented reform agenda and mandate for the Victorian government.

Since this is a dynamic time in workforce growth and models of service, we anticipate consultation cycles beyond this process as further workforce development needs emerge.

The findings in this project provide a blueprint for sustainable training and further establishment of the LLE workforces. The recommendations in this report provide a roadmap for the first steps towards building highly prepared cohorts of LLE workforces – essential for integrated and thriving mental health and AOD service systems.

Our Future: Final Report

Self Help Addiction Resource Centre (SHARC) as the lead agency, was commissioned by Mental Health Reform Victoria (MHRV) to conduct research and consultation to inform the development of recommendations for an introductory training package(s) for the Lived and Living Experience Workforces (LLEWs) in the Mental Health and Alcohol and Other Drug (AOD) sectors in Victoria.

This project was commissioned in response to Recommendation 6[10] of the interim report of the Royal Commission into Victoria's Mental Health System - "all lived experience workers should have access to a minimum, standardised level of lived experience training" and that for all lived experience roles, "training in lived experience work should build on best practice models and be tailored to the Victorian context"(op cit).

This project is the first step in developing and delivering on the crucial recommendation from the Commission.

A literature review of LLE workforce training by The Bouverie Centre – La Trobe University and a desktop audit of available LLE training by The Centre for Mental Health Nursing at The University of Melbourne was augmented by surveys and focus groups facilitated by the four LLE workforces.

We have sought to include the rich discussions between, and the variety of experiences and opinions of, the four distinct workforces, within this report and recommendations.

Recommendations and Commentary

The recommendations in this submission draw on the collective expertise of the Our Future partnership, drawing on the expertise of pioneers from each of the LLE workforces, some dating back from as early as 1996.

This report is structured as follows:

- The recommendations and commentary are organised in four parts:
- **Part A:** Development and Delivery of Training
- **Part B:** Essential Content for Training
- **Part C:** Format and Accessibility of Training
- **Part D:** Context and Structure for Training
- In each section, recommendations are first summarised, then
- Evidence drawn from the project through the literature and desktop review, and the data from the survey and focus groups is summarised to illustrate the evidence that surveys and focus groups inform the recommendations. Particular considerations or assertive commentary on aspects that fall outside the project scope are also provided.
- In addition to these sections, in accordance with our project deliverables, are discussion sections articulating the following:
- **Part E:** Alignment of Currently Available Training with Recommendations for Training
- **Part F:** Risks and Mitigation Strategies for Training

Part A: Development and Delivery of Training

This section reports recommendations and findings from the project related to the development and delivery of training for the LLE workforces.

The way that training is developed and delivered is the foundation building block for ensuring training packages that are relevant, responsive, and able to meet the needs of the growing and diverse LLE workforces.

Recommendation #1: Development and Delivery of Training

To ensure introductory training is relevant and best-practice for the LLE workforces,

1.1 Training is developed and delivered by the corresponding LLE workforce by those who have worked in that workforce and have training expertise.

1.2 The Department of Health delivers focussed investment in developing more workforce specialist educators to build capability for the development and delivery of training.

1.3 Training undergoes a process of continuous evaluation and improvement and requires a formal review process every 12 months with an understanding that, due to the establishing nature of these workforces, this is done to enable discipline development and ensure training upholds best-practice and maintains relevance.

1.1 Training must be developed and delivered by the corresponding LLE workforce by those who have worked in that workforce and have training expertise.

As is standard for all other disciplines in the mental health and AOD sectors, training must be developed and delivered by the workforces themselves. This is the only way to ensure that the training is relevant to the roles and functions of the LLE workforces and implements best-practice, while also contributing to the emerging body of best practice.

Currently LLE workforce training is not consistently developed and delivered by the LLE workforces themselves. The desktop audit found that for each workforce, only 5-50% of available training was developed and delivered by that workforce (see table below, full analysis in Part E of the report). The literature review confirmed this, finding only two training programs (5.3%) that were solely designed by LLE professionals.

> "...it was really a journey across the origins of the movement and to where we are today. So it certainly did give us a great background, you know, to why we were there and, you know, what our purpose was."
>
> mental health consumer focus group participant talking about the value of LLE-led training in consumer perspective supervision

Table 1: available trainings developed and delivered by the corresponding LLEW

Workforce	Number of trainings developed and delivered by the corresponding LLEW that are currently available	Percentages of total available trainings for LLEW that are developed and delivered by the corresponding LLEW
Mental Health Consumer Workforce	10	50%
AOD Lived and Living Consumer Workforce	3	15%
Mental Health Family/Carer Workforce	2	10%
AOD Family/Carer Workforce	1	5%

This lack of access to LLE developed and delivered training impedes the development of the LLE workforces and contributes to peer / role drift and the co-option and clinicalisation of the LLE workforces. It undermines the purpose and focus of LLE work and workers can become co-opted into the dominant clinical understandings, perspectives and roles that they may work within.

> "We need to get hold of those *[consumer created/delivered/led trainings]* so that we're not co-opted into the clinical bandwidth. Sometimes *[training based in clinical work]* is the only available training that we have and it ... doesn't really gel with our discipline."
>
> mental health focus group participant

This is exacerbated by the low numbers of LLE workers, often needing to get by and be supported by, and accepted into, multidisciplinary or other teams, and when available training is developed and/or delivered by clinicians.

> *"[We are] required to do the mandatory training that clinical staff need to do.. no consideration given to our context."*
>
> mental health family/carer focus group participant

> *"I was a sole peer worker across the service, but I was lucky enough to have a bit of a hand over with the person who was in the role previously, who did a great job. And also the Carer Consultant. I think having that carer lived experience perspective, they really helped me to understand what the work was 'cause I think sometimes, I did clinicalise it and that's what you do fall into that because you're in a clinical setting and being the sole person it was really important to have that point of reference that I could go to."*
>
> mental health family/carer focus group participant

In some instances, this co-opting can put LLE workers in conflicted, or even ethically compromised positions and negatively impact on their practice, e.g. around compulsory or coercive practice.

> *"I was lucky enough to have a very strong clinical go-to personal champion that had a really good understanding of carer peer support. And she would be quite strong with me about, "No, you- you know, this is out of your scope." And I needed that. Perhaps... as a carer, we come in and we want to support and care for people. But you know, there's boundaries. It's not that easy to step back and think, "Oh, no this is not part of my role... it needs to go back to the clinical team."*
>
> mental health family/carer focus group participant

This was seen as a particular risk in the mental health sector where LLE workers are more often working in clinical environments unlike the AOD sector in which its history is more closely linked with voluntary and community service environments with more acceptance of LLE work. It is estimated, that in the 1970s, 70% of AOD workers had lived or living experience of addiction.[11]

Scope for inter-LLEW developed training

Along with workforce specific training within each of the four domains (see Part B), there is some potential for inter-LLEW developed training which will create opportunities for cross-workforce understanding and solidarity.

One example would be a LLE-led program developed by mental health family/carers, family/carer workforce and consumers to assist families/carers to learn how they can support relational recovery. This is essential content for mental health family/carer workers who are working directly with families to enhance their understanding of how to support carers to support recovery. It is vital a module like this draws on the combined expertise of relevant workforces.

Examples of other modules that could suit an inter-LLEW development approach include:

- Cross sector orientation to the mental health and AOD sectors
- Orientation to the different LLEW roles where each cohort develops and delivers information about their workforce to other cohorts

Such modules would require a tailored approach to any shared topics, per workforce, as, even when describing the same sector, each workforce may have a differing perspective based on their discipline. This requires further exploration during training development.

Introductory training is an important opportunity to differentiate LLE roles from clinical approaches

Training is a crucial opportunity to establish scope of role, provide context, and provide a philosophical framework for LLE roles - these act as an antidote to clinicalising workspaces.

> "I think for me working in a clinical space, the IPS really gave me a framework to hang things ... and also really protected me from- from co-option....I could always, you know, move back ... to the tasks and principles. So I found that really, really useful".
>
> mental health focus group participant

At present, many LLE workers come into roles in organisations where clinical approaches are the dominant paradigm. For many, LLE developed and delivered training is their first, and often only, introduction and foundation in how LLE work and roles are different from clinical roles. This is a crucial opportunity in LLE workers' professional development to ensure that they are not co-opted or trained to approach their work and take on philosophies or beliefs from a clinical perspective.

Focus group participants identified the complexity and importance of this initial orientation to the system and the necessity to learning to 'walk in both worlds' - the clinical and the lived and living experience world:

> *"when I go into, say, clinical review, there's 20 clinicians and me. And so I need to understand what's going on. And- and understand their language."*
>
> mental health family/carer focus group participant

"When we first did the [documentation] training at our service they were expecting us, as carer workers, just to document as we would [as] a clinician."

mental health family/carer focus group participant

"It was really good to understand the difference between a clinical lens and a peer lens. I learnt the value of relationship with the defined role of Peer Worker."

AOD Consumer focus group participant

1.2 The Department of Health delivers focussed investment in developing more workforce specialist educators to build capability for the development and delivery of training.

Across the LLE workforces, there is a significant and immediate need to build the capability of LLE educators and trainers in order to develop and deliver a set of best-practice introductory training for the LLE workforces. This is a crucial component of meeting the current and ongoing training needs in the sector and requires people with a track record of training expertise as well as having worked in the corresponding LLE workforce.

There is also a preference that training is developed and delivered by trainers with corresponding work experience in specific roles, i.e. peer support trainers should have experience in a peer support role. A range of trainers will be needed from each workforce to ensure the skill and experience in different settings is embedded into development and delivery of training.

Whilst building the capability of LLE educators is relevant for creating sustainable educational opportunities for all LLE workforces, it is noted that in the mental health and AOD family/carer workforces there is a more pronounced shortage of educators. There are few educators in the mental health family/carer workforce, and no funded workforce development roles in the AOD family/carer space.

Alongside investing in the development of introductory training packages, the department should consider investing in the LLE-led development and implementation of a LLE workforce educator capability building strategy for each LLE workforce to meet training demand. The Department will also need to work with LLE educators to develop the implementation plan for this, the details of which are out of scope for this project.

1.3 Training undergoes a process of continuous evaluation and improvement and requires a formal review process every 12 months with an understanding that, due to the establishing nature of these workforces, this is done to enable discipline development and ensure training upholds best-practice and maintains relevance.

The LLE workforces are rapidly changing and will continue to do so in the coming years and decades. Regular review and development of training implementation and content is needed to ensure it continues to meet the needs of the LLEWs.

Regular review of training will also ensure that high quality and continuous improvement is maintained. Specific resources will be needed to undertake rigorous evaluation of training curricula, methods and resources and to obtain user feedback. This needs to be led by the relevant LLE workforce in partnership with educators and learners.

Given LLE workforce training is an evolving body of knowledge and practice, it will take many years to establish itself and mature. Therefore, iterative processes and reviews should be designed to foster growth and evolution rather than assess prematurely.

In order for this project to have value beyond a limited cycle alongside this iterative process, substantial engagement from the Department of Health with the LLE sector is essential.

One example of this type of engagement is the previous 'Consumer Partnership Dialogues' that acted as a regular opportunity for the Department to be exposed to the diversity of the LLE consumer workforce rather than having their understandings of the LLE workforces filtered through industrial groups. Given this moment in the histories of the workforces, and the rapid shifts expected over the next 5-10 years, continual, and comprehensive engagement with the workforces is vital.

Part B: Essential Content for Training

This section contains content outlines (Figures 1-4 on pages 47-61) that illustrate the essential content areas recommended to be covered in introductory training for each LLE workforce in the mental health and AOD sectors.

A '*one-size fits all*' standardized training across all LLE workforces was not recommended by the project partners with a firmly expressed need for area-specific training that reflects the different historical and philosophical roots of each area and the nuance of knowledge and practice required for roles in each area. This makes this recommendation different to the others which apply across all areas. To preserve the specificity differences in essential content these are addressed in detail in the appendicised reports from each area as the basis for further development.

Recommendation #2: Essential Content for Training

To ensure introductory training contains the essential core elements required by the workforces:

2.1. Introductory training for each of the four LLE workforces is developed in accordance with the content outlines developed by the different cohorts, provided in Figures 1-4, Part B of this report.

2.2 Content development is undertaken by the relevant cohorts

2.1. Introductory training for each of the four LLE workforces is developed in accordance with the content outlines developed by the different cohorts.

Few currently available trainings contain the workforce-recommended essential content for introductory training.

The desktop review and consultation clearly identified that for most LLE workforces, no current training covers all the essential training content identified in this project.

The table below shows the currently available training with the highest coverage of recommended content. Full details are in Part E of this report (Alignment of Currently Available Training with Recommendations for Training).

The suite of SHARC AOD trainings and the Carers With training had the best coverage of all

Table 2: coverage of recommended content by currently available trainings

Currently available training with highest coverage of recommended content	Content areas covered of recommended areas	Developed and delivered by corresponding LLEW
Mental Health Consumer Workforce		
Suite of Athena Consumer Workforce Consulting	74%	✓
Intentional Peer Support 5-day core training	65%	✓
Certificate IV in Mental Health Peer Work	48%	
AOD Consumer Workforce		
Suite of SHARC AOD trainings including peer support, consumer participation and advocacy	100%	✓
Intentional Peer Support 5-day core training	62%	✓
Certificate IV in AOD	46%	
Mental Health Victoria Intro to Mental Health Peer Support training	46%	

Currently available training with highest coverage of recommended content	Content areas covered of recommended areas	Developed and delivered by corresponding LLEW
Mental Health Family/Carer Workforce		
Caring With, introduction to carer peer work training* (referred to as Carers With training in this report)	74%	✓
Certificate IV in Mental Health Peer Work	71%	
Mental Health Victoria Intro to Mental Health Peer Support training	71%	
Single Session Family Peer Work training	57%	✓
Carers Vic general public training	57%	
Intentional Peer Support 5-day core training	43%	
AOD Family/Carer Workforce		
Suite of SHARC AOD trainings including peer support and advocacy	54%	
Family Drug and Gambling Phone Helpline training	30%	✓
Intentional Peer Support 5-day core training	29%	
Carers Vic general public training	29%	

* Note: this training is not currently available, but has been included as it shows significant promise

available training covering 100% of the content recommended by the relevant workforce according to analysis from the desktop audit. These trainings also meet the requirements of recommendation 1.1 as they are developed and delivered by the corresponding LLE workforces.

Other notable trainings that the desktop audit analysis found covered over 50% of workforce-recommended content, and are developed and delivered by the corresponding LLEW are:

- Suite of trainings from Athena Consumer

Workforce Consulting with 74% coverage

- Intentional Peer Support 5-day Core Training with 65% and 62% coverage in the mental health and AOD consumer workforces respectively
- Single Session Family Peer Work training which covers 57% of recommended content

Notably, there is no currently available AOD Family/Carer training that is developed and delivered by the workforce and meets the 50% threshold for covering workforce-recommended core content. This indicates that the training landscape for the AOD Family/Carer workforce is considerably further from meeting recommendations presented in this report than other LLE workforces.

More detail on survey respondents and focus group participants' ratings and responses to the currently available training can be found in the consultation reports in Appendices 4-7.

As part of this project, the Subject Matter Experts have developed core content outlines for introductory training. It is recommended introductory training is developed in accordance with these outlines on pages 47-61 of this report.

2.2 Content development is undertaken by the relevant cohorts

When formulating the essential contents for training, all the partners in this project were clear that a one size fits all standardised approach would not meet the diverse needs of the LLE workforces. Each workforce operates from different historical roots with different philosophies, needs and practices. For example, mental health consumer workers operate from a specific discipline known as 'Consumer Perspective' (see Appendix 4 for more details).

The differences between LLE workforces may also be understood by considering other health disciplines. For example, there would be many training topics that look similar across different allied health disciplines, such as recovery or assessment. However, each discipline (e.g. social work, psychology, occupational therapy) has its own interpretation and practice differences requiring training specific for that workforce. The LLE workforces are similar in being a collection of different disciplines.

For example, in mental health, 'recovery' has a meaning developed by the consumer movement and linked to 'personal recovery', that is, creating a meaningful and contributing life.

In the addictions landscape, however, the idea of 'recovery capital' emerged meaning the total resources someone has available to them to maintain their recovery.

Some of the most obvious gaps caused by training not being developed and delivered by the corresponding LLE workforce were apparent in the family/carer workforces where content was not relevant to their roles:

> *"Courses seem focussed on the needs of the person who uses AOD."*
>
> AOD family/carer survey respondent

> *"I was well supported in Vollies role at first organisation, but Dip MH & AOD very focused on the person using, almost to the extent of "demonizing" families."*
>
> AOD family/carer survey respondent

Whilst there are needs for similar topics across workforces (for example, using your LLE, supporting people in suicide/crisis, communicating and working with other professionals, advocacy, self-care), the partners agreed that the meaning of each topic to its corresponding LLE workforce varied and there was a significant difference in how this content would be taught and demonstrated in training across different workforces, given the variety of roles. It is essential these nuances

are embedded in how training is developed and delivered to ensure maximum relevance to each workforce.

> *"I noticed that* [there was] *almost no guidelines about articulating the differences between our roles. So, say, carer consultant and consumer consultant. We have some great relationships we've built there. But it's been on working together on the things that are similar. And, similarly, with carer peer support roles, what are the differences between the roles, and how can we augment each other by being articulate about those differences? I think those things often go missing in the need to find allies, and the need to work together, because you know, we've only got each other, sort of thing. So I think articulating the differences would be really useful work we could all do."*
>
> mental health family/carer focus group participant

It is essential when considering the training content for the four workforces in the following pages that this must be developed and delivered by the corresponding LLE workforce.

> *"...[there is an]* interchangeability that seems to exist between carer lived experience workers and consumer lived experience workers that seems to come from some services. ...I would urge that separation of those experiences."
>
> mental health consumer focus group participant

Differences in priorities and weighting of content areas

Different priorities and weightings for training content is required based on the history, perspective and context of each workforce.

For example:

- AOD LLE workforce training had a focus on delivering modules on practice skills first. There may be a combination of factors for this, e.g. levels of acceptance of lived / living experience roles and high uptake and availability of organisational readiness training in the AOD sector.
- Mental health workforces have a history of systems change focussed roles, with consumer consultant roles emerging early on. These are most often isolated roles within complex power dynamics and so there is more prominence and focus on these content areas in the recommended content.
- Mental health consumer roles have more of a focus on consumer rights given they experience and support those who have had their rights breached to the greatest extent.

Existing training with promising alignment with recommended content

There is a range of existing trainings that meet some of the six recommendations and could feature as part of introductory training packages as they continue to be developed and delivered.

Note: percentages below are calculated based on analysis from the desktop audit.

Examples include:

- Suite of SHARC training for the AOD consumer workforce and the sector. This suite includes the training in peer support, consumer participation, advocacy and organisational readiness, and, across the whole suite provides 100% coverage of the content recommended by the AOD consumer partners.
- Additional to this, the AOD version of the Intentional Peer Support 5-day core training was well-received and seen as a quality training for understanding peer support roles. Developing the AOD version of the training into an online version would ensure it meets format and access recommendations.
- Athena's suite of mental health consumer workforce training provides 74% coverage of the content recommended by the mental health consumer partners.
- The Intentional Peer Support 5-day core training designed for the mental health consumer workforce has 65% coverage of the content recommended by the mental health consumer partners as well as a model for developing new trainers and a bank of trainers currently available.
- The Caring With training has 100% coverage of the content recommended by mental health family/carer workers and Single Session Peer Support has 57% coverage. Whilst the Caring With training is not currently available, the mental health family/carer workforce partners in this project recommended it could be further developed as a basis for introductory training for that workforce.

Further information on how these trainings align with the project recommendations are available in Part E: Alignment of Currently Available Trainings with Recommendations.

Further detail on specific findings to support these recommendations are in the appendix for the corresponding LLE workforce, Appendices 4-7.

Recommended Core Content for LLE introductory training

The following are four outlines of core content for introductory training for the four LLE workforces. These contain high-level outlines of essential content, developed by the Subject Matter Experts engaged in the project from each workforce:

- Mental Health Consumer Workforce Content List – developed by Athena and CMHL
- AOD Consumer Workforce Content List – developed by SHARC
- Mental Health Family/Carer Workforce Content List – developed by CMHL and CLEW
- AOD Family/Carer Workforce Content List – developed by SHARC

These models were developed based on findings from the consultations, as well as the extensive expertise the partners and Subject Matter Experts brought to the project. It is recommended that introductory training for each of the four LLE workforces is developed in accordance with these content outlines developed by each cohort.

The full scope of findings that inform these content outlines are in the corresponding Appendices for each workforce, 4-7.

Mental Health Consumer Workforce Content Outline (Figure 1)

Developed by project partners Athena Consumer Workforce Consulting and the Centre for Mental Health Learning (CMHL).

This is a simplified list; full content outline is included in Appendix 4.

Part 1: Consumer perspective discipline foundations

Scope of practice
- What's in & what's out of consumer roles
- Avoiding co-option/drift
- Consumer perspective as a discipline in its own right
- Difference to family/carer and clinical roles: concepts & values
- Diversity of our roles & settings

Ethics
- Respecting consumer boundaries/consent to share
- Duty of care from a consumer perspective
- Nothing about us without us

Discipline principles
- Values base
- Knowing our perspective, recognising tokenism
- Recognising structural/org issues – new workers need to understand the scale of the challenge, "big, crazy system"
- Vulnerability of our work

Understanding human rights
- History & context
- Class, cultural, disability, feminist, intersectionality, LGBTIQ+

Consumer movement history
- Activism
- Workforce

Part 2: Applied Practice Skills

Use of personal story
- When & how; what & who for?
- Intention & influence

Peer support roles
- Note writing from consumer perspective
- IPS tasks especially connection
- Trauma
- Working with people experiencing suicide and crisis from consumer perspective (Alternatives to Suicide)

Consultant, advisory, advocacy roles
- How to make change, advocate
- Big picture in advocacy (strategy, influence)
- Co-production & co-design/delivery/evaluation/planning
- Welcoming diversity
- Diversity, power & privilege
- Engaging with diverse groups (LGBTIQ+, cultural awareness, dual diagnosis, dual disability)

Part 3: Interpersonal & communication skills

Connection
- Relationships & networking: with the broader consumer community; relational training; enlisting supporters
- Allyship
- Co-reflection
- Group facilitation skills
- Presentation skills

Influence
- Assertiveness: standing up for ourselves, for consumer perspective (especially in clinical settings), getting space in meetings
- Managing conflict
- Power & influence – how to use the power we have, how to have uncomfortable conversations with clinical colleagues

Non-violent communication

Part 4: Ongoing professional preparation and development

Discrimination & workplace safety
- What to do
- Discriminatory wellness plans
- Power

Supervision
- Getting the most out of it
- Importance of discipline specific supervision

Not-wellbeing/surviving in these spaces
- Debriefing
- Dealing with difficult dynamics
- Working with allies, colleagues, and tolerators

Part 5: Practice/sector context

Resources, finance
- Executive & governance structures
- Budgets & funding

Legislative frameworks
- The (new) mental health act
- NDIS legislation
- Workplace rights & industrial protections
- Tribunal hearings

Organisational structures/systems
- Understanding the MH system (and how it's changing)
- Internal processes
- Organisational readiness & resistance
- Working within the system
- Providing feedback

Part 6: Leadership

Career pathways & leadership
- Mentorship
- Championing consumer perspective
- Chairing meetings

Career progression

Note: this is a simplified list; full content outline is included in Appendix 4.

AOD Lived and Living Consumer Workforce Content Outline (Figure 2)

Developed by project partner the Self Help Addiction Resource Centre (SHARC). Full details are included in Appendix 5.

Lived/Living Experience in Practice

Roles and key concepts:
- Types of AOD LLEW roles: group facilitation, advocacy, peer work, advisory and consultant roles, overdose prevention, NSP, leadership (supervisors, team leaders and coordinators)
- Better Practice including Victorian AOD Peer Workforce Core Competencies
- Self-determination, doing with vs doing for

Using our Lived/Living Experience:
- Purposeful Disclosure
  - Making sense of 'our story' and how it shapes our work, editing 'our story' and preparing to be 'known'
  - Limits of sharing your lived/living experience including sensitive areas, managing triggers, how and when to use your own experiences

Working with Others:
- Boundaries: types of boundaries (physical, emotional etc.), professional and personal boundaries with service users and colleagues, conflicts of interest and dual relationships
- Trauma informed care
- Recovery capital – understanding available resources

Communication
- Effective communication and understanding language
- Types of communication
- Active Listening
- Assertiveness
- Conflict resolution and diplomacy
- Psychological safety in the workplace
- Challenging power imbalances
- Having difficult conversations
- Barriers to communication
- Motivational interviewing through a peer perspective

Diversity, Inclusion and Ethical Practice
- LLE perspectives on AOD
- Stigma and discrimination
- Cultural competence
- Ethical standards and practice
- Ethical dilemmas (personal and professional)
- Understanding the overlap between AOD and MH (Dual diagnosis)

Understanding Lived/Living Experience in the AOD Service System

Purpose, History, Principles and Values
- Defining Lived and Living Experience (LLE) Work and its purpose
- Understanding where Lived and Living Experience Work fits within the AOD service system
- History and evidence base of the AOD and MH Lived/Living Experience Workforce:
  - Outcomes and benefits, stigma, discrimination and consumer movements, the importance of language,
  - Vision for the Victorian AOD Peer Workforce, strategy for the AOD Peer Workforce in Victoria (2019), Victorian AOD Peer Workforce Community of Practice
- Lived/Living experience values and principles
- Navigating the AOD service systems: types of services available, diverse approaches ie. Harm reduction and abstinence, understanding different lived/living experience frameworks and methods, collaborative approaches
- Difference from clinical / non-LLE roles and how they can work together

Alcohol and Other Drugs
- Understanding the Victorian Service System and Victorian treatment streams
- Why do people use alcohol and other drugs?
- Different types of drugs and drug use
- Dual Diagnosis
  - Understanding comorbidity including MH, family violence, suicide
- Stages of change model
- Understanding different practice types:
  - Recovery oriented practice and treatment principles
  - Strength Based Practice
  - Harm reduction values and principles

Working in formalised settings

Working in Clinical and Forensic Settings

- Introduction to working as a professional i.e., expectations in a clinical or forensic environment around attire, punctuality, organisational skills and professional conduct
- Working within a multidisciplinary team
- Understanding other roles
- Understanding how to deal with stigma in the workplace
- Role advocacy and scope of practice
- Understanding power dynamics in peer relationships and clinical hierarchy
- Referral processes – promoting referral pathways to LLE workers; knowing how to refer as a lived/living experience worker, the different pathways etc.
- How to practice values and principles of lived/living experience work within a clinical setting
- Working collaboratively
- Critical incident management
- Understanding MH Sector and MH Act 2014

Safety, Risk and Legislation

- Confidentiality and Privacy
- Duty of care
- Informed consent and disclosure
- Understanding governance and legislation
- Organisational policy and procedure
- Understanding and managing risk and what to hold
- Dignity of risk
- Case noting
- Co-writing case notes
- Differences between LLE case noting and clinical case noting

Wellbeing, Personal and Professional Development

Self-care

- Self-care education and tools
- Vicarious trauma
- Well-being tools
- Reflective practice

Supports

- Role Challenges
- Role supports: Debriefing, Supervision (and how to use it)
- Your rights and reasonable adjustments
- Networking (Communities of Practice, co-reflections)

Professional Development

- Career planning/trajectory
- Professional development
- Peer Drift – what is it and how can we identify it?
- Volunteering, mentorship and placement opportunities

Advocacy for the Lived/Living Experience Workforce

Champions for Change

- Understanding consumer rights
- Advocacy and promotion of LE work
- Understanding drivers of change
- "it's not about what we do but how we do it"
- Importance of staying informed about LE initiatives across sectors
- Advisory/CAG groups
- Fair work rights i.e., EFT, benefits and entitlements, advocating for fair role capacity

Note: in the next stages of training development further work needs to be undertaken to delineate distinct content models for the lived experience and living experience workforces. Lived and living experience workers should learn about the other workforce's philosophy (e.g. concepts such as recovery or harm reduction) but it would not be a major focus of training.

Mental Health Family/Carer Workforce Content Outline (Figure 3)

Developed by project partners Carer Lived Experience Workforce (CLEW) and the Centre for Mental Health Learning (CMHL).

This is a simplified list; full content outline is included in Appendix 6.

Understanding family/carer perspectives, experiences and needs

- Language and definitions; 'carers', 'nominated persons', family, young carers consumer
- Understanding families, carers and family dynamics - learnings from lived experience and family systems literature
- Understanding trauma, intergenerational trauma and families
- Diversity and intersectionality of families/carers - needs of CALD carers, Aboriginal and Torres Strait Islander, LGBTIQA+ carers,
- Family/carer movement and advocacy messages
- Family/carer rights

Orientation to the system; mental health, family/carer, disability and AOD

- Understanding the Victorian mental health system from family/carer perspective
- Intersections between the MH, AOD and Disability systems
- Understanding different ways of understanding and responding to 'mental illness' including but not limited to the medical model and diagnosis, trauma
- Introduction to policy and legislative frameworks
- Services and resources for families/carers
- Models of family/carer work in mental health services

Orientation to family/carer work in mental health services:

- What is family/carer lived experience work?
- Family/carer workforce roles
- Role clarity challenges; peer drift peer and being alert to clinicalisation of the role, 'dual roles'
- Making the most of the time you have together; single session framework
- Boundaries and limits as a family/carer worker
- Promoting family/carer work
- Purposeful storytelling/disclosure
- Core communication skills
- Challenges and ethical dilemmas

Workplace wellbeing

- Bringing your lived experience to work
- Burnout/compassion fatigue and vicarious trauma
- Self care and wellbeing tools
- Keeping it real - challenging service expectations
- Moral and ethical dilemmas
- Health and Safety in the workplace
- Workplace rights (Unions, reading your EBA or award, EFT, benefits and entitlements, negotiating flexible work arrangements or reasonable accommodations)
- Supports for you in your role
- Career progression and pathways, honing your skills and improving your practice
- Holding space for your colleagues - co-reflection and debriefing

Working within organisations for change

- Making the most of meetings
- Mechanisms for enabling family/carer voices to be heard
- Co-production and codesign
- Advocating for embedding family carer practice
- Educating other staff about working with families and carers
- Using evidence to drive improvements
- Understanding the mental health policy and legislative frameworks for working with families and carers
- Working strategically, prioritisation and time management

Providing direct support to families in mental health services

- History of peer support
- Tasks and principles of family/carer peer support work
- Making the most of the time together
- Skills sharing with families/carers
- Working with vulnerable and distressed families/carers
- Working as a family/carer lived experience worker within the medical model
- Working collaboratively in a multidisciplinary team
- Peer support work in different settings
- Documentation and data

Facilitating meetings and groups

- Facilitating/running workshops
- Chairing meetings
- Support groups
- Meeting facilitation skills
- Cofacilitation with others

Legend Core content | Role specific content | Electives

Note: this is a simplified list; full content outline is included in Appendix 6.

AOD Family/Carer Workforce Content Outline (Figure 4)

Developed by project partner the Self Help Addiction Resource Centre (SHARC). Full details are included in Appendix 7.

Fundamentals of Family/Carer Peer Work

Scope of practice
- What is Peer Lived/Living (LLE) Work
- Types of LLE Roles/Role Clrity
- Group facilitation
- Advocacy
- Peer Work
- Advisory and consultant roles
- Overdose prevention/harm reduction
- NSP
- What Peer LLE Work Is Not
- What makes up a Family Unit
- Unique needs of Caregivers
- Understanding the Family Unit struggles & unique needs
- Self determination of Consumer vs Family Fear
- Understanding limits & boundaries of working relationships

Philosophy, values & types of peer work
- The Philosophy behind Peer LLE Work
- Recopricity in peer support
- The Values & Concepts of the workforce
- Spectrum of Types of Peer Support
- Informal Peer Support
- Formalised Peer Support
- Intro into Code of Ethics & Principles of Practice

Core Attributes of the Family Carer Peer Workforces

An Exploring of Self & Core Attributes
- Hope and possibilities
- Demeanor
- Communication
- Respect
- Self-Management and Resilience
- Flexibility and Adaptability
- Critical Thinking
- Self-Awareness & Confidence
- Teamwork & collaboration
- Personal integrity
- Continuous Learning & Development

Standards and Principles of Practice

Understanding Standards of practice of Peer Support/LLE work: respect, advocacy, recovery, working in partnership, excellence
Applying Peer LLE principles in diverse environments
Core Values that underpin Peer Support/LLE work: Equal and trusting relationships, mutuality & reciprocity, dignity, respect & trust, self-determination & personal strength, peer support is non-directive, strength based & recovery-focused, peer support is evidence based

Navigating the service system & Workplace

Sector
- Overview of the AOD, MH and Youth systems
- Forensic AOD system
- Navigating the system for consumers and families
- Catchment-based intake services
- Understanding the Mental Health Act 2014
- Services and supports for families
- Understanding Family and Carer Rights
- Knowledge of professional, legal & ethical frameworks

Workplace
- Understanding Workplace Legislation
- Leadership - supervisors, team leaders and coordinators
- Understanding Supervision
- How to deal with stigma & discrimination in the workplace
- Sharing LLE in the workplace
- Understanding power dynamics in the workplace
- Community of Practice
- Making Referrals - knowing how to refer and the pathways of referrals
- Big picture thinking
- Principles of reasonable adjustment

Lived and living experience in practice: Concepts and methods

- Ethical responsibilities
- Conflict of interest
- Professional boundaries & relationships
- Commitment to safe practices
- Safety, risk & legislation
- Domestic violence, financial or material abuse or exploitatin, psychological abuse, sexual abuse or exploitation, neglect
- Connecting with community resources
- Using your lived / living experience
- Building supportive relationships
- Family process of recovery and change
- Diversity & social inclusion
- Fostering self-determination
- Social determinants of health
- Building resilience through self-care and wellness plans
- Purposeful disclosure and mutuality
- Person-centred approach
- Trauma Informed approach
- Communication & barriers to communication
- Motivational Interviewing concept in LLE practice
- Active Listening
- Boundaries
- Doing with vs doing for
- Working with diverse people
- Stigma and discrimination
- Develop advocacy skills for families
- Recovery capital-understanding who is in circle of influence
- Managing conflict
- Crisis situations (self-harm, suicide), meta-competences & strategies
- Dual Diagnosis - understanding complications of comorbidity
- Gambling, AOD and MH relationship

Managing personal wellbeing and professional development needs

Self-care

- Self-care/awareness and tools to maintain wellness & resilience
- Vicarious trauma
- Burnout and compassion fatigue
- Reflective practice
- Moral and ethical dilemmas
- Exploring organisational supports - supervision & debriefing

Professional development

- Career planning
- Accessing professional development
- Volunteering, mentorships and placement opportunities
- Goal setting
- Continual improvement & lifelong learning

Elective modules

- Returning to the workforce skills
- Dual diagnosis (advanced)
- Technology basics - Word, Excel, PowerPoint, Zoom, Teams
- Group facilitation training (advanced)
- Working as a family carer consultant in hospital and community settings (advanced)
- Helpline training
- Dealing with crisis and suicide (advanced)

Note: this is a simplified list; full content outline is included in Appendix 7.

Part C: Format and Accessibility of Training

The format of training needs to support optimal teaching and learning/ pedagogy for an effective learning experience. Modes of delivery must ensure equity of access across the diversity of LLE workforces, geographical distances, including regional services, and organisation types such as large and small organisations.

FORMAT

Recommendation #3: Training Format

To ensure that training is developed and delivered in a format that is responsive to workforce needs:

3.1 Training is tailored to the demographic characteristics, work situation and development needs of the LLE workforces.

3.2 Training is available online and face-to-face

3.3 Training is delivered with diverse learning approaches, i.e. hands on vs theoretical learning

3.4 Training includes formative assessments that do not make training completion prohibitive

3.1 Training is tailored to the demographic characteristics, work situation and development needs of the LLE workforces.

Given the differing histories and development of the LLE workforces, there are different demographic characteristics and needs apparent in each workforce. These differences are outlined in Table 3 on the following page and need to be attended to in the development and delivery of training to ensure that training is accessible to the LLE workforces.

In particular, consideration needs to be made for the part-time, low equivalent-full-time hours (EFT) and voluntary roles, which are common to all LLE workforces. 2019 workforce data puts the average EFT of consumer roles at 0.67 and 0.69 for mental health and AOD respectively. By comparison, the average EFT for mental health family/carer roles is lower at 0.58, making these characteristics more pronounced.[12] The Our Future survey also found 70% of AOD family/carer workers first roles are in voluntary roles, significantly higher than other workforces.

Need to engage rural and regional workforces

Because of the different access needs and low numbers of regional workforce respondents to the consultations, there is a need to do further research to understand the unique needs of regional workers. It is recommended that in the next stage of development there is:

- Additional focus groups with rural/regional workers and/or,
- Strong representation from regional/rural workers in the coproduction group for the development of the training, and
- Prototyping with rural/regional workers.

3.2 Training is available online and face-to-face

This recommendation was common across all workforces.

Online options featured in the top three factors that assist access to training across all workforces in the survey, as seen in the table on page 66.

Developing and delivering training in face-to-face as well as online synchronous learning options will help ensure accessibility, particularly for those living in regional or rural areas and those in low EFT or part-time roles, as is common across these workforces, where availability and travel impacts on the accessibility of face-to-face learning.

Online synchronous learning options can also help address the current limited availability of face-to-face training and lack of organisational resourcing for people to attend face-to-face training. Further assistance from the Department of Health has been recommended later in this section of the report to resolve this second challenge.

However, many LLE roles are practice-based and skills for these roles are more difficult to learn online. So, where possible, face-to-face elements should be incorporated into trainings. This will help with skill consolidation and foster supportive networks amongst trainees - an important factor for the success of training and

Table 3: demographics of workforces and training format needs

Workforce	Demographic characteristics and work situations	Training format needs based on demographic characteristics
Mental Health Consumer Workforce	Workforce is made up of paid permanent roles as well as voluntary positions and casual/ contract work. Predominantly part-time and a mixture of metro and regional roles, most respondents were peer support workers, which is expected as they now consist of the largest group of consumer workers.[13]	Mental health consumer workers spoke about the value and greater need for networking and mutuality in learning processes, suggesting that (synchronous) online and face-to-face training is a preferred option for this workforce over self-paced learning
AOD Lived and Living Consumer Workforce	Workforce contains lived and living experience roles which are significantly different in their philosophical underpinnings and how they approach their roles. Some lived experience workers may find approaches for living experience workforce roles challenging given this.	Lived and living experience workers may need to receive training separately
Mental Health Family/ Carer Workforce	According to the survey, people in family/carer roles are almost exclusively female and often, still, maintain caring roles. The majority are aged over 46 years and are predominantly part-time roles with low EFT.[14]	Training needs to be flexible and delivered over a time period which allows for participation.
AOD Family/Carer Workforce	Vast majority of workers are female, in an older age group, and in voluntary roles who often, still, maintain caring roles.	Training be developed with an (asynchronous) on-line training component to allow for self-paced learning, alongside opportunities for peer-to-peer learning and networking

workforce development as explored further in Part D: Structure and Context for Training. Although face-to-face delivery of training is preferred, the project identified several key barriers to accessing face-to-face training some of which are distinct issues for different LLE workforces.

Table 4: top rated responses for factors that assist with access to training from survey data

Workforce	Top three rated factors that assist with access to training from survey data
Mental Health Consumer Workforce	1. Flexibility of days/hours when training is held 77% 2. Training is held online 72% 3. Allocated budget for training provided by my organisation 59%
AOD Lived and Living Consumer Workforce*	1. Allocated budget for training provided by my organisation 65% 2. Training is held online 65% 3. Flexibility of days/hours when the training is held 58%
Mental Health Family/ Carer Workforce	1. Training is held online 77% 2. Flexibility of days/hours when the training is held 77% 3. Allocated budget for training provided by my organisation 69%
AOD Family/Carer Workforce*	1. Training is held online 61% 2. Allocated budget for training provided by my organisation 48% 3. Flexibility of days/hours when the training is held 39%

*Note: these figures include people in Dual Diagnosis roles.

Building accessibility through self-paced online learning options was least preferred but a necessary option

Given the low EFT of many roles across the LLEWs, particularly in family/carer roles in both the mental health and AOD sectors, self-paced online learning options should be made available when appropriate.

This option would support workforces that require greater flexibility in accessing training due to concurrent roles as carers or other commitments. Further, self-paced online training may be more accessible from a financial perspective which would address financial barriers in sectors where roles are presently characterised by low EFT and/or largely voluntary workforces.

However, the project partners stressed that this is the least preferred, but a potentially necessary, option.

Face-to-face and synchronous online training options contribute to peer-to-peer learning, build workers' networks and professional resources and reduce role isolation. These are crucial aspects to worker skill acquisition, wellbeing and continuous development and workforce retention. If online self-paced options are used, they should be utilised as a last resort when other training is not accessible and should be paired with elements of synchronous peer-to-peer learning and networking.

3.3 Training is delivered with diverse learning approaches, i.e. hands on vs theoretical learning

As is standard in best practice pedagogy, training needs to be developed in a manner that incorporates diverse learning and teaching methods to ensure training is accessible and gives new LLE workers the greatest opportunity to gain the required skills and knowledge from training. Training must ensure it caters to the needs of these diverse workforces.

Of survey respondents from all LLE workforces, 52% identified a peer support role (doing peer 1:1, group or helpline work) as their first LLE role. This is in comparison to the next most common first LLE role at 18% for LLE representatives on Consumer Advisory Groups (CAGs) or advisory groups. Given peer support positions require direct 1:1 or group work and therefore require hands-on, practical training to gain the requisite skills to perform core functions, it is essential to ensure hands-on training is provided as much as is feasible.

3.4 Training includes formative assessments that do not make training completion prohibitive

The desktop audit found that most of the training currently available to the LLE workforces requires no formal or informal assessment. Only eight available trainings (13%) required assessment. However, previous research, as noted in the literature review, found that the majority of consumer workforce participants were in favour of a requirement for formally assessed competency to be addressed in filling consumer workforce roles (Stewart et al., 2008).

The partnership recommends that competencies be demonstrated through the use of formative assessments used to monitor learning and provide ongoing feedback to ensure assessments do not make training completion prohibitive. These types of assessments support the transfer of knowledge and acquisition of skills without introducing barriers to qualification and are "intended to promote further improvement of student attainment."[15]

Formative assessments are needed given the entry-level nature of the recommended training and to ensure training is accessible to the diversity of people who join the LLE workforces who may have had disadvantaged and disrupted schooling, educational and career opportunities.

As an example, the Intentional Peer Support (IPS) training includes a final presentation where trainees demonstrate their understanding of the IPS tasks and principles. This presentation must be completed to receive a certificate of completion, however, participants are not assessed on their presentation and a number of accommodations are made such as participants presenting just to facilitators or handing in a written presentation.

ACCESS

Recommendation #4: Accessibility of training

To ensure that all training is accessible to the workforces:

4.1 All workers have access to introductory workforce training within the first 12 months of employment.

4.2 All Training is state-funded or, at a minimum, subsidised by the Department of Health

4.3 The Department of Health mandates release during work hours for LLE workers to engage in training. Those workers working part-time, be given adequate paid study leave to complete their training.

In addition to this, we recommend that further work be undertaken by the Department to ensure that systems are in place to ensure policy levers, as well as accountability measures, are in place to ensure accessibility to any introductory training.

4.1 All workers have access to introductory workforce training within the first 12 months of employment.

The survey identified that 22% of survey respondents did not receive any training in their first 12 months of work.

AOD consumer focus group respondents described their first year of employment as "being thrown in the deep end" and that, without training in their first year, "we had to pretty much feel our way through it".

This carries with it substantial risks to organisations, workers and the LLE workforces more widely:

- Workforce injury (physical or psychological) due to lack of training and supports to mitigate against workforce harms
- Potential harms to those supported by untrained LLE workers which could also disincentivize organisational investment and support for LLE workforces
- Peer drift and co-optation of peer roles, resulting in undermining the LLE workforces broadly

These examples underscore the vital need for training in the first 12 months. Lack of such training would not be accepted by other professional groups in the sector, e.g.: counsellors, nurses, doctors etc.

Table 5: most common barriers to training (selected by over 50% of survey respondents)

Workforce	Most commonly selected barriers to training from the survey
All LLE workforces	1. Lack of time in role to attend training (63%) 2. Limited or no budget for training in role (61%)
Mental Health Consumer Workforce	1. Limited or no budget for training in role (58%) 2. Finding time in my role to attend training (52%)
AOD Lived and Living Consumer Workforce*	1. Finding time in my role to attend training (92%) 2. Limited or no budget for training in my role (80)%
Mental Health Family/ Carer Workforce	1. Finding time in my role to attend training (74%) 2. Limited or no budget for training in my role (63%)
AOD Family/Carer Workforce*	1. Limited or no budget for training in role (75%) 2. Finding time in my role to attend training (83%)

*Note: these figures include people in Dual Diagnosis roles.

4.2 All Training is state-funded or, at a minimum, subsidised by the Department of Health

The biggest barriers to training are cost and lack of ability to get time release to attend training. In regard to cost, the survey found 61% of respondents named limited or no budget for training in their role as a barrier to training. For example an AOD family/carer volunteer worker noted they would need:

> *"Financial support as I would need to take time away from my paid job to take on further study."*
>
> AOD family/carer survey respondent

Given the majority of LLE workers are in low paid and/or low-EFT roles, it is essential that training is state-funded or, at a minimum, subsidised. Wholly state-funded training is recommended given that subsidised funding can incentivise organisations to make LLE training, like the Certificate IV in Mental Health Peer work, a prerequisite for applying for LLE positions. Given the need to rapidly expand the LLE workforces and attract more people to take up LLE positions, subsidised, instead of state-funded training, will stymie these efforts.

As the survey demonstrates, new LLE workers who have not previously completed training often do not have a professional development budget tied to their role. This further makes the case for state-funded training as even subsidised training may still not be accessible to those in paid LLE positions.

In regards to time to attend training, 63% of survey respondents saw lack of time as a barrier to training.

4.3 The Department of Health mandates release during work hours for LLE workers to engage in training. Those workers working part-time be given adequate paid study leave to complete their training.

63% of survey respondents saw lack of time as a barrier to accessing training. After lack of time and budget (61%), the next most highly rated barrier was not knowing which training workers to do, with 35% of respondents indicating this as a barrier. These results indicate that time and budget are the two major barriers to access.

For LLEWs working in the public mental health system, the Enterprise Bargaining Agreement (EBA) does not stipulate that LLEWs have access to study leave or professional development leave. Access to this leave is therefore at the discretion of managers which often means only those confident to negotiate with their manager, those working for managers who are invested in LLE workforce development and those whose managers have the ability to make these kinds of budgetary decisions are able to access study or professional development leave. If any of these factors do not fall in favour of the individual LLE worker, they will rarely be able to access study leave. This creates substantial barriers for individual workers to overcome.

Attending training also has a potential impact on workload with time in training impacting on time to do the work. This was relevant to all workforces given the average EFT for LLE roles was 0.63 – noting average EFT was higher for consumer roles (~0.67), and lower for mental health family/carer roles (0.58).[16] AOD family/carer roles were not reported and assumed to be far lower given the high proportion of first

roles being voluntary (70% from survey).

Mandating release is particularly critical in rural areas but is also an issue in smaller metropolitan services where there is no one to backfill positions and no urgency to fill roles.[17]

We recommend that further work be undertaken by the Department to ensure that systems are in place to ensure policy levers, as well as accountability measures, are in place to ensure accessibility to any introductory training.

At present, there is great variability in organisational support for LLEW training. As such, there needs to be policy levers organised centrally to ensure training is made accessible. Mandated release is one such measure, but the Department of Health needs to consider developing a comprehensive strategy to ensure accessibility of training. Some ideas are presented in the Part F: Risks and Mitigation strategies, such as:

- Flexible delivery options, as discussed in Recommendations #3
- Department of Health mandates that all LLE workers have an allotted training budget
- Ensure protected "in work" time to attend training including encouraging services to have a bank of casual LLE workers to backfill positions while workers attend training
- Services to be paid to backfill positions to attend training, e.g. Eastern Health have a casual bank of LLE workers. Monash Health similarly develops Consumer Advisory Group (CAG) members' knowledge and skills so there is a pathway for them to move into other LLE roles as they become available.

Part D: Structure and Context for Training

Training is essential for people entering, contributing and progressing in the LLE workforces, for the benefit of consumers and families/carers. Training is only effective when the organisational context supports application of learning and has appropriate structures to support and integrate these workforce roles.

Training of individual LLE workers in and of itself is not enough to ensure LLEWs are prepared and equipped to work effectively in their roles.

ORGANISATIONAL SUPPORTS

Recommendation #5: Organisational supports

To ensure LLEW working environments are safe and supportive for workers, the Department of Health resource the following strategies:

5.1 Organisations employing LLE workers undertake organisational readiness training to make certain that all (non-LLE) colleagues understand the nature of LLE work; the LLE workers' experience and knowledge base; and the skills required to work alongside the LLEW

5.2 LLE workers are provided with access to discipline-specific supervision, co-reflection, mentoring and networking with other LLE workers to ensure knowledge translation and contextualising learning to the workplace

5.3 Organisations encourage, resource and fund the professional development of the LLE workforces. This includes LLE apprenticeships, traineeships, line management, and supportive performance development opportunities to support early career pathways.

5.1 Organisations employing LLE workers undertake organisational readiness training to make certain that all (non-LLE) colleagues understand the nature of LLE work; the LLE workers' experience and knowledge base; and the skills required to work alongside the LLEW

Across the LLE workforces, it was clear that many of the issues LLE workers face, and one of the key barriers for LLE workers being able to work effectively and utilise their skills and knowledge, is lack of organisational support or understanding.

These barriers surface as:

- Organisations and staff not understanding what LLE work is
- Organisations asking LLE workers to do activities outside of the scope of their role
- Organisations that were hostile to LLE ways of working

This lack of organisational readiness is illustrated throughout the consultation reports (Appendices 4-7):

> *"I was in a very supportive organization in my first volunteer peer role so had supervision, training, supportive work culture and training however in other organizations I have since worked at, I have tried to advocate for the organization to embrace peer workforce and there has been reluctance, lack of respect for lived experience workforce or understanding of the value, stigma and ignorance etc so combating those would be most important."*
>
> AOD family/carer survey respondent

> *"I hate the idea of training consumers how to work better within systems without having training to train systems on how to work better with consumers. And I think, where it feels like we're almost training consumer workers to put on an armour and sending them into battle and saying, 'Here, we've equipped you, now go and fight this fight on your own...' But we're not lacking the base level skills and understanding of our role. It's our organizations that are questioning what we're doing constantly to the point that we start questioning what we're doing ourselves..."*
>
> mental health consumer focus group participant

There are a variety of reasons why organisations have, to date, struggled to make the changes required to ensure thriving LLEWs. The CMHL Organisation Readiness Project identified that lived and living experience workforces are not currently well resourced, authorised or widely respected. There is also a lack of opportunities to be elevated to leadership levels in services where LLEWs can drive organisation change and readiness. For organisational change programs to be effective there needs to be willingness for change, commitment to change, organisations

"I have tried to advocate for the organization to embrace peer workforce and there has been reluctance, lack of respect for lived experience workforce or understanding of the value, stigma and ignorance etc so combating those would be most important"

AOD family/carer survey respondent

and individuals must see the benefits of change, and there must be the ability to make the changes including time, resources, and leadership.

The literature review also found role confusion as a common issue; research papers recommend organisational leadership and commitment to LLEWs as a remedy including creating a culture of accepting the LLE workforces to ensure successful integration of the LLE roles. The partnership has recommended further work to remedy this in Recommendation #6.

The project partnership strongly endorsed the need for any introductory training of LLE workers to be matched with a complementary training for organisations. As recommended for introductory training for the LLE workforces themselves, organisational training should continue to be iterated in a way that shows commitment to continuous understanding, improvement and review.

> "...we're not lacking the base level skills and understanding of our role. It's our organizations that are questioning what we're doing constantly to the point that we start questioning what we're doing ourselves..."
>
> mental health consumer focus group participant

Essential content for organisational readiness training

The project partnership recommends that an organisational readiness training be developed alongside a set of introductory LLE workforces trainings. Organisational readiness training development should be led by the LLE workforces with input from non-LLE workforces and should contain the following core content:

- Overview of the different LLE disciplines
- Overview of the variety of LLE roles and their scope including ways that LLEW practices are different from clinical practices e.g. collaborative note taking, boundaries and non-coercive practices as they relate to the mental health consumer workforce
- Ways that staff and management should resource the development of the LLE workforces
- How organisations and staff can support the LLEWs to exercise power and decision-making ability including how to avoid being tokenistic
- How to provide safe and respectful working conditions for LLEWs e.g. anti-discrimination practices, understanding of, and provision of, reasonable supports to the consumer workforces and flexible work arrangements
- Additionally, for services employing family/carer workers in mental health and AOD, organisations need to be trained, committed to and demonstrate family-inclusive practice and relational approaches to recovery

Whilst it is out of the scope of this project to assess and recommend specific organisational readiness training, an example of a Victorian peer-led organisational readiness training with merit is the SHARC Organisational Readiness training, which is LLE-led in its development and has been delivered since 2014.

5.2 LLE workers are provided with access to discipline-specific supervision, co-reflection, mentoring and networking with other LLE workers to ensure knowledge translation and contextualising learning to the workplace

Throughout the consultations, it was clear that training is only one part of the solution to ensuring LLE workers are adequately prepared and supported to perform their work effectively. As with other workforces in the mental health and AOD systems, it is vital that LLE workers are provided with access to the supports that enable implementation of learning and ongoing development. All partners agreed that all workforces required access to:

- Discipline-specific supervision
- Mentoring
- Co-reflection
- Networking opportunities

> "...quality supervision, including externally, is essential - probably more important than any course or qualification in my view"
>
> mental health consumer focus group participant

> "I had to wait three years to get peer supervision. It changed everything."
>
> mental health consumer focus group participant

Discipline-specific supervision, including external supervision offering choice that matches role type, co-reflection, and mentoring serve to consolidate training and should be based on the basic principles of continuous practice improvement to complement classroom training.

"I had to wait three years to get peer supervision. It changed everything."

mental health family/carer focus group participant

"I had access to this, but quality supervision, including externally, is essential - probably more important than any course or qualification in my view."

AOD family/carer focus group participant

Networking within each individual LLEW is an essential support for workers within at least the first 12 months of their career so that they can share experiences, learn new strategies and engage in mutual support.

> *"Definitely I think that connection to the movement is, is really important, for me particularly around resilience as well."*
>
> *"...that connection to the movement is, you know, it's so empowering, and it's such a game changer and it really helps you."*
>
> mental health consumer focus group participants

LLEWs also need access to combined networking opportunities across LLE workforces to ensure a non-siloed set of workforces, mutual understanding of each other's roles and solidarity across LLEWs.

This recommendation aligns with Recommendation 6 from the Interim Report of the Royal Commission into Victoria's Mental Health System, in particular, access to support and career structures for lived experience workers, where it identified the need to offer these supports as an antidote to stigma, role isolation, lack of organisational support and unclear roles and responsibilities for LLE workers.

5.3 Organisations encourage, resource and fund the professional development of the LLE workforces. This includes LLE apprenticeships, traineeships, line management, and supportive performance development opportunities to support early career pathways.

The project partners recommend organisations incorporate a cycle of continuous improvement and capability building into their professional development plan for all LLE workers and volunteers. Structural requirements are needed to support LLE workforce capabilities, for example, being able to work in a team of LLE workers and having a number of senior LLE workers in a service, including in management and executive roles. In particular, no LLE workers should be working in isolated roles.

> *"How do I then take on the next steps in my career development? Both professionally in terms of skills building... and subsequently hopefully for others. So how do we... not just look at supporting people to get into that workforce, but create opportunities for the organizations in which they work to help them navigate through it? In a way that they have the right to a career in that sort of sense, as any other healthcare professional does as well."*
>
> mental health consumer focus group participant

Organisations can consider the following areas to start professional development, for example:

- The AOD consumer partners suggested organisations could name volunteering opportunities as development opportunities
- Investing in CAGs & other advisory groups is a vital component in upskilling future LLE workforces; this is where many LLE workers have their first experiences of involvement in LLE work.

Of all the LLE workforces, the consultations identified that AOD Family/Carer workforce had the highest rates of voluntary roles with 70% of survey respondents identifying as their first

role as being voluntary compared to the mental health consumer workforce where 77% of first roles were paid.

This was further seen in the difficulty in recruiting members of the AOD family/carer workforce to take part in the consultations as they, largely, did not see themselves as part of a workforce. This explains the lower recruitment of AOD family/carer workforce for this project where there were 23 survey respondents and 13 focus group participants from the AOD family/carer workforce. This is compared to mental health family/carer workforce which saw 52 survey respondents and 25 focus group participants.

Consideration needs to be made as to how to grow and build the AOD family/carer workforce given the high proportion of volunteer roles. Further work is needed to consider how training is developed and delivered and how career pathways are currently, and could be planned, to recruit this workforce.

" "How do I then take on the next steps in my career development?... how do we... not just look at supporting people to get into that workforce, but create opportunities for the organizations in which they work to help them navigate through it?"

mental health consumer focus group participant

ESSENTIAL DEVELOPMENT

Recommendation #6: Essential development of LLE workforces

To ensure the sustainability and further establishment of the LLE workforces as professions, the Department of Health resource the following strategies:

6.1 Develop stewardship strategies to establish and sufficiently resource professional bodies to support, advocate and develop the LLE professions.

6.2 Investment in organisations that provide vital support functions for LLEW such as: advocacy and representation of the workforces, professional development, networking, mentoring, and community of practice.

6.3 Investment in LLE workforce-led research to build the LLEWs disciplinary perspectives, which are vital to developing training content.

6.4 Development of discipline-specific role descriptions for LLEWs to enable consistency. Those designing role descriptions to have significant expertise of working in that role and expert knowledge of any theoretical and philosophical underpinnings of the relevant discipline.

6.5 The provision of genuine opportunities for career development, leadership opportunities and articulation into existing educational pathways, especially as the LLEWs rapidly grow. Partnerships with Universities and TAFES to achieve this goal to be explored.

6.6 As an interim measure in lieu of a specific professional body, LLE workers should have access to specialist LLE educators.

6.1 Develop stewardship strategies to establish and sufficiently resource professional bodies to support, advocate and develop the LLE professions.

Unlike other workforces in the mental health and AOD sectors, the LLE workforces currently operate without the infrastructure, or without the sufficient infrastructure, that other disciplines and professions can rely on to develop, support and advocate for them. Most notably, they operate without established professional bodies that would support professional development, support investment in workforce research, advocate for LLE workforces and further progress the professionalisation of the workforces. One mental health consumer survey respondent described what was needed and the gaps this omission creates:

> *"A dedicated peak body or union that can respond to the unique pitfalls that occur, particularly in the clinical sector - VMIAC has limited time, [Independent Mental Health Advocacy] is out of scope, [the Mental Health Complaints Commissioner] can't take on cases/give an answer on if they will take on cases quickly enough, and [the Health and Community Services Union] don't understand or support LE work"*
>
> mental health consumer survey respondent

This lack of infrastructure was seen as a major roadblock to the development of the workforces broadly and has had a significant impact on the development of the disciplines at present and will continue to do so. This has a significant impact on training, given the establishment period that the workforces find themselves in at present. Many of the workforces are still emergent and theoretical work and research is needed to provide the intellectual and theoretical infrastructure that would be incorporated into training.

For example: "understanding the values and principles of the LLE workforces" was a topic that came up as high priority across the consultations for new LLE workers to understand, yet, not all LLE workforces have the fully embedded understanding of these values and principles to be able to incorporate them into training. This is due to the lack of investment in LLE workforces in general and, in particular, in LLE workforce-led research.

"[We need a] dedicated peak body or union that can respond to the unique pitfalls that occur, particularly in the clinical sector"

mental health consumer survey respondent

Given the key role LLE workforces are tasked with playing, and the emerging nature of these workforces, the partnership recommends that the Department of Health play the market stewardship role needed to and plan, cost and fund work to investigate what is needed to establish and sufficiently resource professional bodies for these workforces.

6.2 Investment in organisations that provide vital support functions for LLEW such as: advocacy and representation of the workforces, professional development, networking, mentoring, and community of practice.

In the interim, before professional bodies are properly established and sufficiently resourced, the partnership recommends several approaches to developing critical foundations and infrastructure for these workforces in the following decades.

Investment is needed in organisations that support the LLEWs. Many of the vital functions in developing, delivering, and supporting training are currently being conducted by organisations that are under-funded and under-resourced or this function is not part of the scope of their work.

This gap between need and available organisational workforce support is likely to become more pronounced as the LLE workforces grow in the next stages of reform in Victoria's mental health and AOD systems. It is imperative that the Department of Health invest in organisations that support the LLE workforces to establish a set of well-supported LLEWs.

6.3 Investment in LLE workforce-led research to build the LLEWs disciplinary perspectives, which are vital to developing training content.

The literature review and consultations identified a significant lack of foundational philosophical and theoretical research on which to build the methodologies, approaches and content that would be delivered in LLE training compared with those of other disciplines such as social work and occupational therapy.

Whilst some LLE workforces have a more solid foundation to their work, such as the mental health consumer discipline, all workforces are in need of significant investment and this is particularly pronounced when compared to the research and literature base of other professions in the mental health and AOD fields.

There are also a number of workforce-specific issues that the partners identified that need to be addressed through LLE-led research:

- Mental health consumer workforce: there is a long international history of theoretical and philosophical foundations for this discipline. Further research is needed to explore experiences of workplace bullying, discrimination, parity, peer drift and co-option, work conditions and the organisational supports this workforce identifies as helpful. Although there has been work in this area through the Leading the Change report (2020), more needs to be done.
- Family/Carer workforces (AOD and mental health): urgently require support to build the disciplinary perspective and teaching academics.
- AOD Consumer workforce: training for the AOD workforces has been developed

and continues to be driven by both lived and living experience workers; these are two different disciplines with different philosophies and ways of working.

- Research into how multiple lived and living experiences shapes peoples' work, e.g. for someone who has a history of drug use who is also a family member of someone who has substance use issues. While the partners would not support dual LLE roles, there is value in exploring how the different perspectives and advocacy messages of both groups, carer and consumer, inform their work.

6.4 Development of discipline-specific role descriptions for LLEWs to enable consistency. Those designing role descriptions to have significant expertise of working in that role and expert knowledge of any theoretical and philosophical underpinnings of the relevant discipline.

For the sake of clarity, this means there will be Position Descriptions for each role, in each LLE workforce. For example, all mental health peer workers will be working to the same Position Description.

Currently, many LLE workers are working without a relevant Position Description and further work is needed to ensure the scope of practice for LLEW roles is standardised and effectively established. Ongoing work will need to be done in this area as the workforce undergoes significant growth and change in the next 5-10 years.

> *"[what would have helped was]* a clear position description, what exactly the role was, how the service works, the push back I may have faced, boundary setting with families and colleagues, how to develop the carer peer service"
>
> mental health consumer focus group participant

There is a risk that the LLE workforce will otherwise perform functions that are outside of the scope of their role, and organisations may inadvertently engage members of the LLE workforce in activities that will result in 'role drift' or 'role strain' such as performing tasks that clinicians would perform.

Additionally, there is a risk that, without Position Descriptions that recognise the uniqueness of the different LLE workforces and roles, organisations will continue to see consumer and family/carer workers and perspectives as interchangeable and their roles as generic. This means organisations will continue to make recruitment decisions that set the worker up for difficulties when they come to implement the LLE role.

> "[what would have helped was] *a clear position description, what exactly the role was, how the service works, the push back I may have faced, boundary setting with families and colleagues, how to develop the carer peer service"*
>
> mental health family/carer focus group participant

6.5 The provision of genuine opportunities for career development, leadership opportunities and articulation into existing educational pathways, especially as the LLEWs rapidly grow. Partnerships with Universities and TAFES to achieve this goal to be explored.

The LLE workforces show significant appetite for further study and career progression with 63% of survey respondents indicating they were interested in further study. Career planning happens at the very beginning of a person's paid employment or volunteer work in a sector and, without a clear career structure and pathways, people move on or choose not to enter the LLE workforces. This lack of career development opportunities was cited in consultations as a reason not to engage in training at all given the narrow focus and opportunities in the LLE workforces at present:

> *"I would not want to 'waste' a Commonwealth supported training place for lived experience training as I do not feel it is a very transferable skill, or that there are many related jobs - and may mean I can't access other comm. funded training."*
>
> AOD family/carer survey respondent

The literature review found 83.3% of trainings identified were for introductory or entry level positions. The desktop audit confirmed that the vast majority of the trainings currently available to the Victorian LLE workforces were entry level.

> *"So we have a fairly new role... the Lived Experience Coordinator position, but it doesn't hold any, anything really, kind of sits off to the side and it's very unclear as to what that position is meant to do in relation to your line manager who is often a service manager with many, many other responsibilities."*
>
> mental health family/carer focus group participant

> "I think it would be fantastic if in years to come, the workforce can keep developing to a point that there are actually kind of pathways in place... I just think it would be really beneficial to have a bit more of a structural pathway to follow... I know there's probably a long way to go before we get to that. But I think that's it."
>
> mental health consumer focus group participant

> *"I think it would be fantastic if in years to come, the workforce can keep developing to a point that there are actually kind of pathways in place. So, when you are entering the workforce, you are set up with a mentor, you do have supervision without having to pay for it... I just think it would be really beneficial to have a bit more of a structural pathway to follow, almost like a graduate year... I know there's probably a long way to go before we get to that. But I think that's it."*
>
> mental health consumer focus group participant

Training must be considered in conjunction with career development and pathways

Introductory training cannot be the end-point of career progression; further training is required for LLE workforce members and the workforces as a whole to reach their potential and to fully embed LLE perspectives and practices. Without the further development of career pathways, the workforces will stagnate instead of mature.

Some strategies to build the career pathways include:

- Investing in CAGs as a vital component in upskilling future LLE workforce - this is where many people have their first experiences of involvement in lived experience work
- Supporting LLE leaders to become role models of people who have developed their career and are able to support others in the LLE workforce community
- Incorporating opportunities to rotate through different areas of the service / services similar to a "grad nurse program". This would need to be in collaboration with organisations that have an active LLE workforce and established support structures.
- Offering traineeships to provide options for organisations to employ subsidised trainee LLE workers at a reduced cost to the organisation whilst ensuring the worker be paid in line with relevant EBA/awards. This would increase employment options for LLE workers and lower wage costs for organisations to make it a more attractive option.
- Providing Recognition of Prior Learning (RPL) pathways to other training e.g. Certificate IV, and recognition of past training e.g. Intentional Peer Support, Certificate IV in Mental Health Peer Work, Single Session Peer Work be considered.
- Ensuring that services are recognised for supporting their workforces to complete trainings.

6.6 As an interim measure in lieu of a specific professional body, LLE workers should have access to specialist LLE educators.

Given the development of a LLE workforce within a service is often associated with creating system change at the same time, there needs to be specialist LLE educators available to support practice change within services.

The consultations identified many instances where people received training but found that their organisation was not aligned with LLE values and so the full benefit of the training was lost and individual workers were still isolated and unable to effect desired changes. LLE workers need access to visits/expertise from independent external LLE leaders to consult with to support them and their organisation's development.

> *"...another thing that was really helpful for me as well was having people [consumer leaders] come and visit the service that I was working for... I was watching them do their thing, they would also be nurturing you at the same thing and encouraging you to do your thing."*
>
> mental health consumer focus group participant

Part E: Alignment of Currently Available Training with Recommendations for Training

The following table in this section is an excerpt from the full Desktop Audit (see Appendix 3). It lists currently available trainings, scored against the recommendations in this report.

For Victorians, there are a number of trainings available for the various lived experience workforces; some of these trainings are available for all the workforces whilst others are targeted to specific workforces.

The following table is an excerpt from the full Desktop Audit (see Appendix 3). It lists currently available trainings, scored against the recommendations in this report, where information was available. Note, trainings from the same provider have been grouped together to give a rating of each provider's full suite of trainings.

Each training was given a score out of a maximum 29 points assessed on the basis of information as to how the training was developed and delivered (Part A), its coverage of the recommended content (Part B), format (Part C) and current availability.

Table 6: criteria for assessing alignment of current training with Our Future recommendations

Criteria	Maximum points awarded
Developed by corresponding LLEW	7
Devlivered by corresponding LLEW	7
Coverage of recommended content (Assessed against recommended content in Part B)	10
LLE trainers available (Training is available in the next 6 months)	2
Available in online and face-to-face formats (Available in the next six months)	3
Maximum score (Represented in the table on page 90-91 as a percentage)	**29**

Maximum points available for each criteria were based on the relative importance of each criteria to assessing the suitability of each training.

This resulted in an overall rating for suitability of training for each workforce, indicated by colour coding in the following table.

By this rating system, it is evident the variability exists in the suitability of training. This is also the case within specific training programs across the four LLE workforces.

Table 7: colour coding for scores assessing training alignment

Colour code and alignment	Score	Percentage (approx)
Low quality alignment	0-9	0-33%
Medium quality alignment	10-19	34-66%
High quality alignment	20-29	67-100%

Name or Provider	Brief description	Developed by	Delivered by
Alignment of Currently Available Training with Recommendations for Training			
Alternatives to Suicide Training	Introduction to the model of Alternatives to Suicide	✓	✓
Association of Participating Service Users (APSU)	An introduction to AOD Consumer Peer Support Work	✓	✓
ASIST	A suicide intervention model		
Athena Consulting	Suite of consumer trainings covering history, principles, ways of working	✓	✓
Bouverie Centre	Single Session Family Peer Work training	✓	✓
Carers Vic	General training for any and all carers. Note: these trainings are not specifically designed for the workforce.		

Coverage of recommended content Training content assessed against recommended content (Part B of report)	LLE trainers available	Online and face-to-face	MH Consumer	AOD Consumer	MH Family/ Carer	AOD Family/ Carer
30% 23% 0% 8%		✓	69%	17%	10%	14%
0% 92% 0% 15%	✓	Face-to-face only	7%	86%	7%	14%
0% 8% 0% 8%		✓	10%	14%	10%	14%
74% 38% 0% 0%	✓	✓	90%	31%	17%	17%
0% 0% 57% 8%	✓	✓	17%	17%	86%	21%
0% 0% 57% 29%		✓	10%	10%	31%	21%

Name or Provider	Brief description	Developed by	Delivered by
Alignment of Currently Available Training with Recommendations for Training			
Caring With, introduction to carer peer work	Entry level training for new mental health family/carer workforce in Victoria. Note: delivered in 2016 and 2017, not currently available*	✓	✓
Certificate IV in AOD	An accredited training for people wanting to know more about alcohol and drug use/dependency		
Certificate IV in Mental Health	An accredited training for people wanting to know more about mental health		
Certificate IV in Mental Health Peer Work	An accredited training for people becoming mental health peer support workers		✓ ✓ **
eCPR	Introduction to the support model of eCPR (Emotional CPR)	✓	✓ ✓
Family Drug & Gambling Help	Phone Helpline Training	✓	✓

Coverage of recommended content Training content assessed against recommended content (Part B of report)	LLE trainers available	Online and face-to-face	MH Consumer	AOD Consumer	MH Family/ Carer	AOD Family/ Carer
26% 30% 100% 46%	N/A	N/A	10%	10%	83%	17%
9% 46% 0% 15%		✓	14%	28%	10%	17%
22% 8% 14% 0%		✓	17%	14%	14%	10%
48% 23% 71% 8%	✓	✓	59%	24%	66%	21%
35% 15% 28% 8%	✓	✓	79%	24%	52%	21%
0% 13% 0% 30%	✓	Face-to-face only	7%	10%	7%	66%

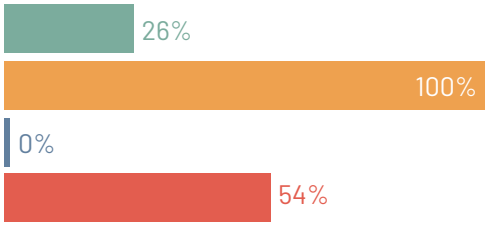
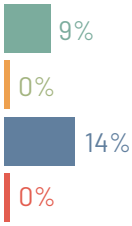
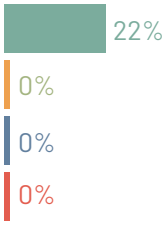
Name or Provider	Brief description	Developed by	Delivered by
Alignment of Currently Available Training with Recommendations for Training			
Inside Out	Training for people wanting to be consumer lived experience supervisors	✓	✓
Intentional Peer Support	Introduction to the Intentional Peer Support Model	✓ ✓	✓ ✓
Lived Experience Transformational Leadership Academy (Let(s)LEAD)	Six-month lived experience transformational leadership program	✓	✓
Mental Health First Aid	Providing general mental health support		
Mental Health Victoria	Introduction to the concept of mental health peer support	✓	✓
Roses in the Ocean	Suicide Prevention Peer Support Training	✓ ✓	✓ ✓

Coverage of recommended content Training content assessed against recommended content (Part B of report)	LLE trainers available	Online and face-to-face	MH Consumer	AOD Consumer	MH Family/ Carer	AOD Family/ Carer
17% 8% 0% 0%	✓	Online only	62%	10%	10%	10%
65% 62% 43% 29%	✓	✓ Face-to-face only for AOD	90%	76%	31%	28%
26% 8% 0% 0%	✓	Online only	66%	10%	7%	7%
0% 0% 0% 8%		✓	10%	10%	10%	14%
30% 46% 71% 15%	✓	✓	76%	34%	41%	24%
35% 0% 57% 0%	✓	✓	79%	17%	86%	17%

Name or Provider	Brief description	Developed by	Delivered by
Alignment of Currently Available Training with Recommendations for Training			
SHARC	Suite of AOD trainings including peer support, consumer participation and advocacy	✓	✓
TACSI Co-Design Training	Co-Design Training	✓	✓
Voices Vic	Hearing Voices Training	✓	✓

Note: *the Caring With training is outside the scope of the desktop review as it is not currently available, but has been included as it was recommended by the mental health family/ carer workforce partners that it be used as a foundation for building a training in alignment with the project recommendations

**the Certificate IV in Mental Health Peer Work has some variability in trainers' expertise and experience working in the LLE workforces

Coverage of recommended content Training content assessed against recommended content (Part B of report)	LLE trainers available	Online and face-to-face	MH Consumer	AOD Consumer	MH Family/ Carer	AOD Family/ Carer
	✓	✓	28%	100%	17%	34%
	✓	✓	69%	17%	21%	17%
	✓	✓	72%	17%	17%	17%

Part F: Risks and Mitigation Strategies for Training

In accordance with the Our Future project plan, the following section articulates the risks inherent in the development and delivery of introductory training packages for the LLEWs, as well as suggested mitigation strategies.

Risk	Likelihood of occurence	Outcome
Development and delivery of training		
Insufficient investment in, and planning for, workforce(s) capability required to design and deliver training	Moderate	Moderate
Training review is undertaken and results are used as justification for de-investing in training for the LLEWs	Moderate	Major
Evaluation reveals training does not address all of workforce needs	Low	Moderate
Training for the LLEWs is co-opted by clinical organisations or consultancy firms without grounding in the LLEWs and loses connection to the values, strengths, philosophies, perspectives and ways of working of each of the LLEWs	Moderate	Major

Suggested mitigation strategies

- Plan, cost and fund a capability and skills audit for skilled educators in each LLE workforce to identify the number of current educators from each workforce with the skills and expertise to develop and/or deliver introductory training, as well as identify how to build on these numbers to meet training demand
- Develop and cost a strategy for meeting need
- Ensure funding for adequate supervision for all involved in developing training and education
- Plan, cost and fund a strategy for identifying people who would be suitable to develop the training and education
- Fund dedicated mentor positions for those involved in development of training
- Fund dedicated training design and delivery positions by workforce to develop training and upskill other trainers

- Evaluations must be undertaken from the mindset that this is an emergent set of workforces; this means evaluations are not instigated with the intention they could be used to justify halting further development of LLE workforce training.

- Training is developed and refined by experienced LLEW from the corresponding workforce
- Evaluation outcomes incorporated into regular review of training programs

- Training for each workforce to be "housed" within a LLE-led organisation which has experience and expertise in workforce development to ensure training continues to be developed and delivered in a manner that is independent of clinical perspectives
- If the above is not possible, other options are to:
  - House each workforce training within an organisations that has shown authentic commitment to progressing the goals of the LLE workforces
  - Deliver bulk of training outside of clinical organisations themselves

Risk	Likelihood of occurence	Outcome
Training is hosted by organisations without experience and commitment to broader LLE perspectives, literature and workforce goals, over time the value and point of difference of LLEW training is diluted, leading to unintentional peer drift and co-option	Moderate	Major
Essential content for training		
A suite of introductory trainings for the LLEWs are developed but do not cover all core content identified as essential by the workforces	Low	Moderate
Accessibility of training		
Training is inaccessible due to workers living in regional or rural Victoria	Low	Moderate
Training is inaccessible due to low EFT of role (e.g. only 1 day per week)	Low	Major
Training is inaccessible due to cost	Moderate	Major

Suggested mitigation strategies

- Training should be hosted in LLE-led organisations, or alternatively organisations with a commitment to LLE work and goals. At minimum, training should not be hosted by clinical organisations due to the risk of the dominant clinical paradigm diluting LLE training and the potential for unique differences in the workforces to be diluted.

- Development of LLE workforce training packages be done with comprehensive consultation with the LLE workforces themselves, including differing role types
- Iterative process and formal review of training content is inclusive of ongoing feedback from training participants to ensure training is regularly refined to meet the needs of those entering the LLE workforces

- Create both online and face to face versions of training

- Services encouraged to commit to sufficient protected 'in work' time for release to attend training
- Flexible delivery options for those in low EFT, voluntary positions or with current caring responsibilities
- Recognition for services who support people to complete the training

- Government fully funds places in the training so it is of no cost to people
- Alternatively, at a minimum, the cost to attend training is low or is subsidised by government
- Department of Health mandate that all LLE workers have allotted training budget to be used at their own discretion
- That organisational professional development budgets be all-inclusive of the training needs of all staff and volunteers

Risk	Likelihood of occurence	Outcome
Training is inaccessible due to inability to be backfilled while participating in training	Moderate	Major
Employers may only employ people who have already completed training, creating a barrier to both employment and training	Moderate	Moderate
Inadequate funding means that not all members of all workforces can receive training	High	Moderate
Training is not taken up due to little awareness of the training	Low	Moderate
Lack of buy in from LLEW sector	Low	Moderate
Structure and context for training		
Training without establishing genuine opportunities for career development means the sector cannot retain LLE workers, which stymies growth and maturation of LLE disciplines	High	Major

Suggested mitigation strategies

- Ensure protected "in work" time to attend training - including strategies like encouraging services to have a bank of casual LLE workers to backfill positions while they attend training
- Services to be paid to backfill positions to attend training, e.g. Eastern Health have a casual bank of LLE workers. Monash Health similarly develops Consumer Advisory Group (CAG) members' knowledge and skills so there is a pathway for them to move into other LLE roles as they become available.

- Fully-fund training to ensure organisations aren't unduly incentivised to make training completion a prerequisite
- Develop and implement an incentive strategy to encourage services to employ untrained staff to support the growth of the workforces

- Funding to be allocated equitably to ensure that all workforces can be trained. This may mean that some workforces receive more funding as they are larger
- Sustainability strategy required

- Plan, cost and fund promotion strategy to ensure awareness across the sector of introductory trainings for the LLEWs
- Training developed and delivered through thorough consultation with the sector, including developing buy-in from key stakeholders

- Ensure comprehensive consultation and communications with the sector throughout the development and roll-out of the training
- Training co-produced and delivered by people with credibility in the workforces, across the differing role types and LLEWs

- Plan, cost and fund audit of current careers pathways in each of the LLEWs
- Plan, cost and fund career development strategy for the LLEWs which articulates future career pathways, leadership opportunities and future educational pathways

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1 Actual and perceived conflicts of interest: Why both matter, Independent Broad-based Anti-corruption Commission, retrieved from: https://www.ibac.vic.gov.au/publications-and-resources/ibac-insights/issue-21/actual-and-perceived-conflicts-of-interest-why-both-matter

2 State of Victoria, Royal Commission into Victoria's Mental Health System, February 2021. Recommendation 6, Chapter 18, pp 515-516: https://finalreport.rcvmhs.vic.gov.au/download-the-interim-report/

3 Data collected by peak bodies for workforce census, 2020.

4 Data collected by peak bodies for workforce census, 2020.

5 Data collected by peak bodies for workforce census, 2020.

6 Data collected by peak bodies for workforce census, 2020.

7 Lived Experience Workforce Strategies Stewardship Group (2019). Strategy for the Family Carer Mental Health Workforce in Victoria. Centre for Mental Health Learning Victoria (CMHL): Melbourne.

8 Department of Health and Human Services, (2018). Working together with families and carers: Chief Psychiatrist's guideline. Melbourne: Victorian Government.

9 Experience Workforce Strategies Stewardship Group (2019). Strategy for the Family Carer Mental Health Workforce in Victoria. Centre for Mental Health Learning Victoria (CMHL): Melbourne.

10 State of Victoria, Royal Commission into Victoria's Mental Health System, February 2021. Recommendation 6, Chapter 18, pp 515-516: https://finalreport.rcvmhs.vic.gov.au/download-the-interim-report/

11 This has reduced to only 30% of workers in lived or living experience roles as the AOD workforce has professionalised.

12 Lived Experience Workforces Positions report, Department of Health, 2020.

13 Lived Experience Workforces Positions report, Department of Health, 2020.

14 Lived Experience Workforces Positions report, Department of Health, 2020.

15 Summative assessment is intended to summarise student achievement at a particular time, whereas formative assessment is intended to promote further improvement of student attainment, for example p see Crooks (2001) \ Ministry of Education, New zealand, retrieved from: https://assessment.tki.org.nz/Using-evidence-for-learning/Gathering-evidence/Topics/Formative-and-summative-assessment

16 Lived Experience Workforces Positions report, Department of Health, 2020.

17 Lived Experience Workforces Positions report, Department of Health, 2020.

Appendices

01. Methods
02. Literature Review
03. Desktop Audit Report
04. Mental Health Consumer Workforce Consultation Report
05. AOD Lived and Living Consumer Workforce Consultation Report
06. Mental Health Family/Carer Workforce Consultation Report
07. AOD Family/Carer Workforce Consultation Report

Note: appendices are individually numbered

Appendix 1: Methods

This appendix provides an overview of methods undertaken on the four components of the project. Further detail on analysis is given in the individual appendicised reports from project partners.

CONTENTS

1. Literature Review

The literature review was a systematic search informed by PRISMA guidelines (Moher et al., 2015) across four databases using four concepts:

- Lived experience (LE) (peer, consumer, carer)
- Workforce (worker, support)
- Training (education, learning)
- Mental health or AOD contexts

The eligibility criteria for inclusion were: peer-reviewed publication in English that were cross-sectional, prospective, experimental, quasi-experimental or qualitative studies that examined training for a workforce role for trainees with lived experience (personal or in a carer role) of a mental illness or alcohol and other drug (AOD) problem, or lived experience (LE) of treatment settings as a consumer or carer. Papers were excluded if they did not contain original data.

Titles and abstracts and full-texts of identified records were screened by two reviewers using Covidence software to facilitate screening. Discrepancies were resolved by discussion. Data was extracted by one reviewer using a standardised form. Narrative synthesis of extracted data is presented in this report.

Further information on the literature review and analysis undertaken is available in Appendix 2 of this report.

2. Desktop Audit

The desktop audit obtained information about lived experience workforce trainings available in Victoria and Australia. The first source of information was the project team which included some of the most experienced and expert trainers in the lived experience sector. Team members helped identify known providers and other experts to ensure no trainings were undiscovered.

An Internet search was also done on terms that included “Consumer OR Carer Training Victoria”, “Consumer OR Carer Workforce Training Victoria”, “Lived Experience Workforce Training Victoria”, “Peer Support Work Training Victoria”, “Consumer OR Carer Consultant Training Victoria” and “Consumer OR Carer Representative Training Victoria”. The first 10 pages of search results were explored for all relevant training.

The available data was constructed in an excel spreadsheet that identified:

- Title, Description, Provider, Location, Cost, Duration, Objectives, Content
- When the training is running?
- Method of Delivery
- Who designs and delivers the training
- Which workforce/s is it available for?

- What career level is it for?
- Prerequisites and does it involve assessment?

The training program data was then analysed in light of the project recommendations about development, delivery, content and access. These recommendations were used as quality markers with which to appraise the known training offerings, based on available data. This analysis is tabled in the report as the results of the desktop audit.

Further information about findings from the desktop audit are available at Appendix 3 of this report.

3. Survey of Lived and Living Experience Workforces

A self-reported survey with quantitative and qualitative questions was designed by the project team and delivered online. It captured LLEWs experiences of training - what worked well, what could be improved, what should be included in an introductory training for the lived / living experience workforces (LLEWs).

The survey contained 23 questions, including qualitative and quantitative questions. These covered:

- Demographic information
- LLE work experience
- Training in the first 12 months of entering the LLE workforces
- Important topics for new LLE workers to understand
- Training that is not recommended for the LLE workforces
- What helps and hinders access to training
- Interest in further education
- Other key supports in the first 12 months of entering a LLE workforce role

Full survey questions are listed in the following section.

Recruitment was run through invitations to participate through multiple channels including the project partners and others, for example: VMIAC, CMHL, Tandem, VAADA, SHARC, HRVic, MHVic, Orygen, CLEW, Basecamp groups, APSU, Turning Point, Banyule Comm Health. People were directed to the project website to complete the survey online.

After completing the survey, participants could choose to enter a random prize draw for one of 10x $100 gift cards.

There were 275 completed surveys, with 71 removed for:

- Respondents who did not work in a designated LEW role, with an exception for those in CAG or representative roles (n=15)
- Respondents not from Victoria (n=15)
- Respondents who only answered demographic questions (n=41) and did not complete any questions in response to training, as this would skew our demographic data.

The remaining 204 records were separated into the four LEW areas in order to undertake workforce specific analysis:

- MH Consumer, n=61
- MH Family/Carer, n=52

- AOD Consumer and Dual Diagnosis Consumer, n=55
- AOD Family/Carer and Dual Diagnosis Family/Carer, n=23
- Responses in "other" where it was unclear where they fit, n=13

All data was then provided to the Subject Matter Experts for analysis.
Note: it was decided by the Subject Matter Experts to include those in Dual Diagnosis roles in the AOD survey data as it was determined the AOD and Dual Diagnosis roles have more overlap in terms of workforce issues and needs.

Analysis of quantitative survey questions was undertaken by Roshani Prematunga from the Centre for Mental Health Nursing. This information was provided to the Subject Matter Experts.

Subject Matter Experts undertook analysis of qualitative survey responses in the four workforce cohorts. Further information on methods of analysis undertaken is provided in the corresponding appendices.

3.1 Survey Questions

Demographics	
1. What is your age?	Response
2. As part of your current role, where do you work?	Response
	Other (please specify)
3. What is the highest level of education you have completed so far?	Response
	Other (please specify)
4. Do you identify as:	Aboriginal
	Torres Strait Islander
	Culturally and linguistically diverse
	LGBTIQA+
	Living with a psycho-social disability (psycho-social)
	Living with a disability (other than psycho-social disability)
	Refugee or asylum seeker
	Other (please specify)
5. What gender do you identify with?	Open-Ended Response
Work experience	
6. Total time spent working in a lived experience role?	Response
7. What was your first lived experience role?	Response

(Explanatory note: Select the option that best describes your first lived experience role)	Other (please specify)
8. What sector was this role in? (select one)	Response
	Other (please specify)
9. Was this role paid or voluntary? (select one)	Response
	Other (please specify)
10. What perspective were you working from in this role? Select the option that best describes the perspective you worked from in your first role)	Response
	Other (please specify)
Experience of actual training in the first 12 months	
11. What training did you do in the first 12 months (or before you started) your first lived experience role?	APSU LEAP Training (previously called Peer Helper Training)
	ASIST training
	Caring With: orientation to carer lived experience work
	Certificate IV in AOD
	Certificate IV in mental health peer work
	Certificate IV in mental health
	Drug Overdose Peer Education
	Dual diploma mental health and AOD
	Emotional CPR (eCPR)
	Foundations of Peer Work (Mental Health Victoria/Vicserv)
	Intentional Peer Support (5-day core skills)
	Mental Health First Aid
	PeerZone training
	SHARC Peer Worker Training
	SHARC Peer Mentors in Justice Training

	SHARC group facilitation training
	Time for a Change Dual Diagnosis LEW training
	Training in facilitating peer groups
	Organisation-run introduction to peer work training. If so please specify your organisation in the "other" option below
	I received no training
	Other (please specify)
12. Which of these trainings felt **most important or relevant** to you?	APSU LEAP Training (previously called Peer Helper Training)
	ASIST training
	Caring With: orientation to carer lived experience work
	Certificate IV in AOD
	Certificate IV in mental health peer work
	Certificate IV in mental health
	Drug Overdose Peer Education
	Dual diploma mental health and AOD
	Emotional CPR (eCPR)
	Foundations of Peer Work (Mental Health Victoria/Vicserv)
	Intentional Peer Support (5-day core skills)
	Mental Health First Aid
	PeerZone training
	SHARC Peer Worker Training
	SHARC Peer Mentors in Justice Training
	SHARC group facilitation training
	Time for a Change Dual Diagnosis LEW training

	Training in facilitating peer groups
	Organisation-run introduction to peer work training. If so please specify your organisation in the "other" option below
	None of the trainings I did felt relevant to my role
	Other (please specify)
13. Please describe why the above training felt the most **important or relevant** to you	Open-Ended Response
Most important training topics	
14. What topics do you feel are **most important** to cover in the first 12 months as a new lived experience worker?	Open-Ended Response
15. This is a list of common content across current entry-level training for lived experience workers in Victoria. Pick up to five that you think are the **most important topics** for new lived experience workers to understand.	History of the Consumer Movement or Carer Movement
	The discipline of Consumer or Family/carer Perspective
	Roles in the lived experience workforces
	Co-production, co-design
	Using your lived experience (as a consumer or family/carer)
	Boundaries
	Guardianship, power of attorney and other legal decision-making
	Supported, shared and substitute decision making
	Assisting people who are suicidal or in emotional crisis
	How to facilitate groups (for consumers or family/carers)
	Phone helpline training
	Drug overdose training
	How to advocate for someone or yourself

	Dual diagnosis
	How to communicate with other professionals
	How to navigate the mental health and/or AOD system
	How to care for yourself
	How to work with people in the forensic system
Training - do NOT recommend	
16. Is there any training that you have personally done that you **wouldn't recommend** lived experience workers do?	APSU LEAP (Lived Experience Applied) Training (previously called Peer Helper Training)
	ASIST training
	Caring With: orientation to carer lived experience work
	Certificate IV in AOD
	Certificate IV in mental health peer work
	Certificate IV in mental health
	Drug Overdose Peer Education
	Dual diploma mental health and AOD
	Emotional CPR (eCPR)
	Foundations of Peer Work (Mental Health Victoria/Vicserv)
	Intentional Peer Support (5-day core skills)
	Mental Health First Aid
	PeerZone training
	SHARC Peer Worker Training
	SHARC Peer Mentors in Justice Training
	SHARC group facilitation training
	Time for a Change Dual Diagnosis LEW training
	Training in facilitating peer groups

	Organisation-run introduction to peer work training. If so please specify your organisation in the "other" option below
	None
	Other (please specify)
17. If you named a training above, why would you **not recommend** it for new lived experience workers?	Open-Ended Response
Access	
18. Which of the following help you **access** training?	Training is held online
	Training was held close to where I work
	Hours of work are backfilled while I'm at training
	Flexibility of days/hours when the training is held
	Allocated budget for training provided by my organisation
	Protected training time for lived experience professional development (eg. allocated time isn't used up by mandatory fire training)
	EBA/award contains provision for study leave and professional development hours
	Other (please specify)
19. Which of the following make it harder for you to **access** training?	Limited or no budget for training for my role
	EBA/award does not stipulate minimum professional development hours or provision for study leave
	Finding time in my role to attend training
	Working regionally / remotely
	I have access needs (e.g. wheelchair user, Deaf)
	Limited proficiency with technology
	Limited access to technology (hardware or software) required

	It's not clear what training I should do
	Feeling like I should be spending my work hours supporting people (eg. consumers on the ward, family/carers in crisis)
	Other (please specify)
Further education	
20. Are you interested in completing **further education** in lived experience perspective work? This could be a certificate, or (if it was available) a diploma or degree in lived experience work.	Response
21. If you answered yes above, what **further education** are you (or would you) be interested in?	Certificate
	Diploma
	Degree
	Masters
	PhD
	Other (please specify)
22. What **barriers** (if any) do you see to you pursuing a **tertiary qualification** in lived experience work?	Open-Ended Response
Other early career supports	
23. Our Future is about giving people who are new to Lived Experience roles the best chance to succeed in their job and enjoy a flourishing career. We know this involves training, but **what else** do you think would have been important **to support you** in your first 12 months?	Open-Ended Response

4. Focus Groups with Lived and Living Experience Workforces

Focus groups were used to examine LLEWs perspectives of training to understand the elements that worked well in their training experiences and to capture ideas for improvement as well as suggestions for components that should be included in an introductory training for the LLEWs. Several of the focus groups also began to focus on the need for an enabling context for training.

Recruitment was part of the same invitation to the survey (see above) and participants were individuals in paid and voluntary LE roles, this included people in Consumer Advisory Groups (CAGs) or advisory roles.

Baseline questions were developed in collaboration with all Subject Matter Experts, with expertise brought in from project partner Bridget Hamilton (CMHN) to refine focus group questions.

The Subject Matter Experts decided on the following broad lines of questioning for the focus groups:

1. What were the most useful topics you learned as a new LLE worker?
2. What do you wish you'd known in your first year as a new LLE worker?
3. What training or topics wouldn't you recommend?

There was some variation in questions asked in the focus groups for each workforce as Subject Matter Experts refined these questions as they conducted multiple focus groups and in response to the needs of each workforce. Further detail can be found in the corresponding appendices.

There were 96 participants across 15 focus groups:

- 29 in MH Consumer
    - 8 of these attended a focus group specifically for MH Consumers on CAGs or committees
- 25 in MH Family/Carer
    - 7 of these attended a focus group specifically for MH Family/Carers on CAGs or committees
- 29 in AOD Consumer
- 13 in AOD Family/Carer, including 1x 1:1 interview given the lesser numbers

Participants were reimbursed $110 via eftpos gift card for the 2-hr focus group (if they could not take part as part of their current role) in line with Department of Premier and Cabinet guidelines[1] on remuneration of $55 p/h.

The focus groups were conducted on recorded video conferencing (Zoom) and led by people who work in the sector and corresponding workforce.

The recordings were transcribed and thematically analysed by the LLEW Subject Matter Experts in each of the four workforces.

A post focus group survey captured demographic data (same as in the survey) and 88 participants completed this. This information was provided to the Subject Matter Experts to include in analysis of the consultations.

[1] This is as per Department of Premier and Cabinet Appointment and Remuneration Guidelines, Schedule C, Band 1 day rate

Appendix 2: Literature Review Report

Authors: Siân A McLean, An T Vuong, Jessica E Opie, & Peter McKenzie

Partner organisation: The Bouverie Centre, La Trobe University

Appendix 2. Literature Review Methods and Findings

Authors: Siân A McLean, An T Vuong, Jessica E Opie, & Peter McKenzie

Though the authors use the term Lived experience in this literature review, the final report refers to the workforces as Lived and Living experience (LLE).

Methods

Design

A rapid literature review informed by PRISMA guidelines (Moher et al., 2015) with systematic searching was conducted.

Eligibility criteria

Inclusion criteria were: a) peer-reviewed publication in English; b) cross-sectional, prospective, experimental, quasi-experimental or qualitative studies that examined training for a workforce role for trainees with lived experience (personal or in a carer role) of a mental illness or alcohol and other drug (AOD) problem, or lived experience of treatment settings as a consumer or carer. Papers were excluded if they did not contain original data.

Search strategy

Four databases were searched for the concepts: a) lived experience (peer, consumer, carer), b) workforce (worker, support), c) training (education, learning), and d) mental health or AOD contexts.

Study screening and data extraction

Titles and abstracts and full-texts of identified records were screened by two reviewers using Covidence software to facilitate screening. Discrepancies were resolved by discussion. Data was extracted by one reviewer using a standardised form. Narrative synthesis of extracted data was conducted.

Results

Study selection

The database search revealed 2724 records, 2432 remained after removal of duplicates and were subject to title and abstract screen. Following exclusion of 2,339 records, 93 were assessed through full-text screening, with 36 assessed as eligible for inclusion.

Study characteristics

Included studies used quantitative, qualitative, and mixed methodologies and were conducted in a range of countries. See Tables 1, 2, and 3 for details. The training programs that were the subject of the research were predominantly for consumer training (80.6%) and the majority of identified training programs (80.6%) were for the mental health sector. Few trainings (10.5%) were for family/carer roles, although it is noted that 3 studies (7.9%) did not specify if the training for consumer or family/carer roles. In addition, most training programs (83.3%) were aimed at the

introductory level. Duration of training varied from 5 hours to 1.5 years. Due to the small number of studies for family/carer roles and within the AOD sector and overall heterogeneity of study types, it was not possible to compare content and outcomes across training programs offered for different lived experience disciplines and in different sectors.

Involvement of lived experience

Involvement of lived experience consumers or carers was limited in the research and in development and delivery of the training programs. Research authors were affiliated with a variety of settings, with most affiliated with a university or health/community service. Only few (9.7%) had affiliations that represented consumers or carers. Author background or practice discipline was identified for less than half (45.7%) of corresponding/lead authors. Of these, only 5.9% reflected a lived experience background or discipline.

Information pertaining to the background or practice discipline of training developers or deliverers was similarly underreported with 18 (47.37%) and 13 (34.21%) of studies not reporting who designed or delivered training, respectively. When information was reported, a low proportion of training programs had lived experience involvement. Five programs were co-designed by lived experience consumers with clinicians or researchers or through consumer consultation. Only two were solely designed by lived experience consumers (in mental health). Similarly, only two training programs were delivered independently by lived experience peers (one in mental health and one in AOD), one delivered independently by mental health advocates, and six were co-delivered by lived experience peers (consumers or advocates) and health professionals.

Training content, methods of teaching and learning, and delivery

Most training programs (*n* = 28) included solely coursework, while 10 programs included course work and a practical training component. Seven programs provided specific post-course follow-up supervision. Training content (described in 33 or the 36 included papers) is shown in Figure 1.

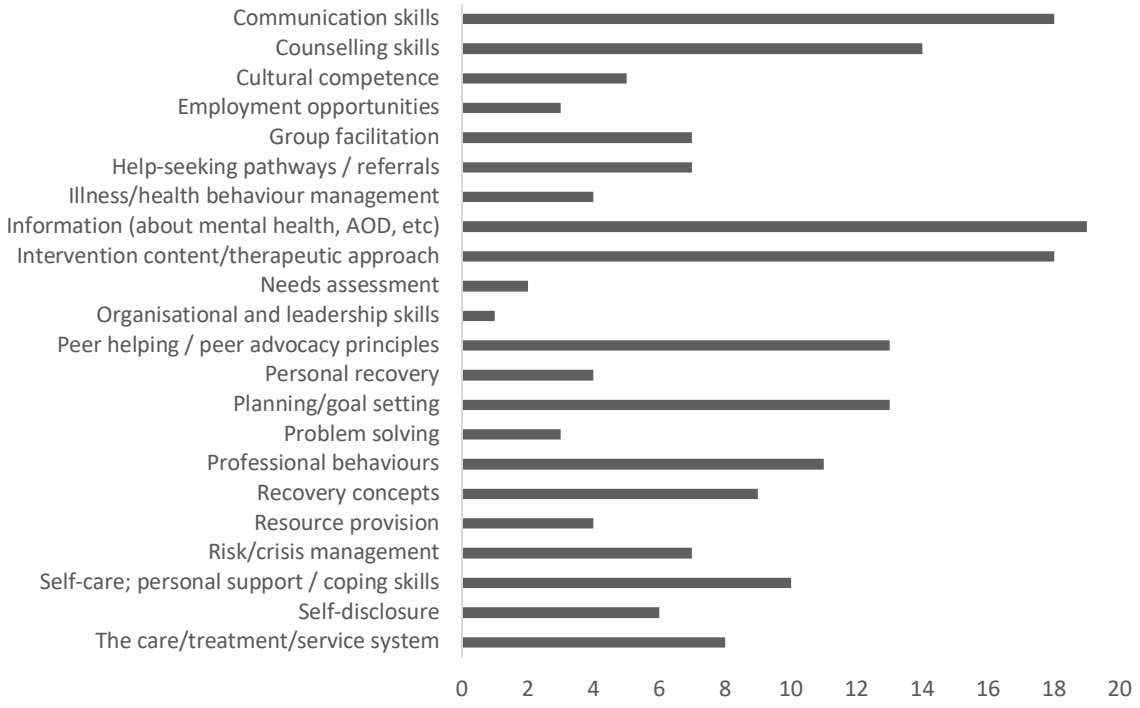

Figure 1

Type of content included in training programs

Note. Personal recovery refers to content regarding the trainees' own personal recovery journey. Recovery concepts relates to principles or foundations of recovery as applied to work with persons receiving mental health or AOD services.

Methods of delivery of teaching and learning (described in 27 of 36 papers) is shown in Figure 2. Where delivery mode was described (28 of papers), most training programs (n = 25) were indicated as having been delivered in person, with two in blended modes and one comparing on-line versus in-person delivery.

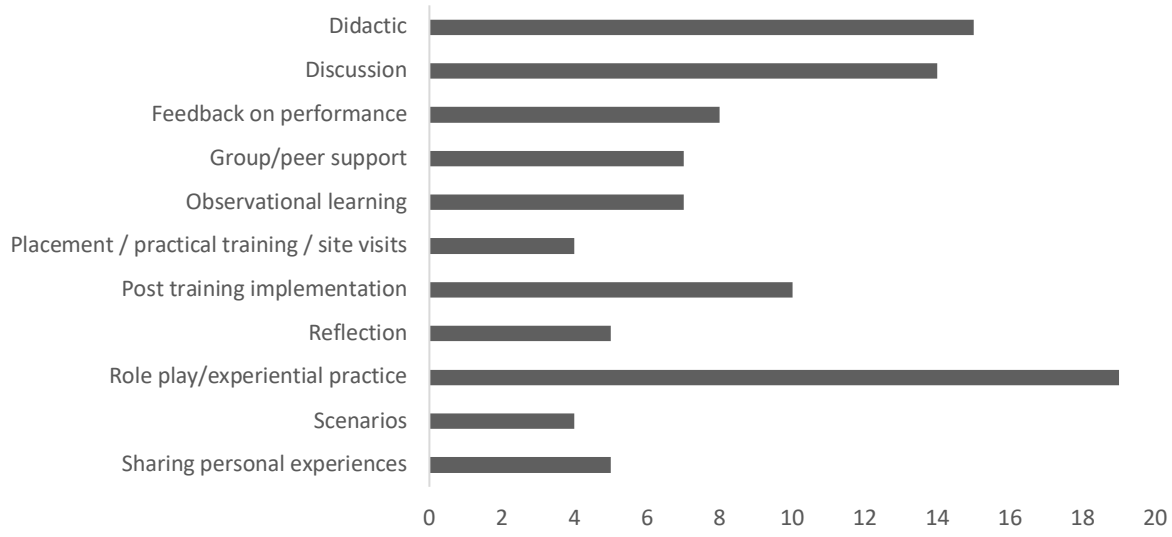

Figure 2

Methods of teaching and learning in delivery of training programs

Findings from Training Participation

Study findings are described in Tables 1, 2, and 3. Ten outcome themes were identified. In order of frequency of occurrence, these were outcomes related to professional development (*n*=28), training satisfaction/utility (*n* =20), personal development (*n* =18), training limitations (*n* =19), training applicability (e.g., fit for purpose; *n* =10), post-training employment (*n* =7), trainee reservations (*n* =7), post-training education (*n* =6), personal barriers to training participation/completion (*n* =6) and mental health service-self efficacy (*n* =4).

Perceptions of Training

Training programs were generally perceived to be useful or beneficial (Atif et al., 2019; Cleary, Hunt, Malins, Matheson, & Escott, 2009; Deren, Kang, Mino, & Guarino, 2012; Franke, Paton, & Gassner, 2010; King, Lloyd, Clune, & Allan, 2009), trainees were highly satisfied with the training (Cleary et al., 2009; Crisanti, Murray-Krezan, Karlin, Sutherland-Bruaw, & Najavits, 2016), and training programs were perceived as providing adequate preparation for current of future roles (Cronise, Teixeira, Rogers, & Harrington, 2016; Franke et al., 2010; Simpson, Quigley, Henry, & Hall, 2014). In regard to the latter point, post-training reports indicated that trainees were able to utilise skills learned during training in their subsequent roles (Bentley, 2000; Deren et al., 2012; Gammonley & Luken, 2001; Joo, Hwang, Gallo, & Roter, 2018; King et al., 2009; Rodriguez et al., 2011; Stoneking & McGuffin, 2007; Toikko, 2016; Willging et al., 2016).

Professional Context

For professional context related outcomes, training participants reported improved knowledge in understanding of mental illness and of prevention practices and greater understanding of motivational interviewing styles and strategies (Blixen et al., 2015; Joo et al., 2018; Treloar, Rance, Laybutt, & Crawford, 2012; Weeks et al., 2006; Wolfe et al., 2013). Improvement in skills were observed for counselling ability, communication and collaborative skills, motivational interviewing competence and practice, confidence working with diverse populations, self-efficacy in navigating the mental health system, and general competencies and overall professional skills (Atif et al., 2019; Compton et al., 2014; Crisanti et al., 2016; Gerry, Berry, & Hayward, 2011; Hoagwood et al., 2018; Joo et al., 2018; Meehan, Bergen, Coveney, & Thornton, 2002; Rodriguez et al., 2011; Tsai et al., 2017; Willging et al., 2016). Attitudes towards consumers of mental health and AOD services and towards conducting peer health work were also found to have improved following training (Cleary et al., 2009; Weeks et al., 2006).

Outcomes related to continued professional development or future workforce roles were also examined. Following completion of training, increased participation in educational or additional vocational activities was reported (Cronise et al., 2016; Deren et al., 2012; Franke et al., 2010; Gammonley & Luken, 2001; Rapp et al., 2008). Trainees developed a positive orientation towards their careers and increased rates of employment post-training were commonly found (Deren et al., 2012; Franke et al., 2010; Gammonley & Luken, 2001; Hegedüs et al., 2021; Hegedüs, Seidel, & Steinauer, 2016; Rapp et al., 2008; Stockmann et al., 2019; Toikko, 2016; Tse, Tsoi, Wong, Kan, & Kwok, 2014; Wolfe et al., 2013).

Limitations of Training

Trainees' perceptions of training programs revealed some limitations. These were perceived to be lack of depth or breadth in coverage of topics (Meehan et al., 2002; Sanchez-Moscona & Eiroa-Orosa, 2021; Stockmann et al., 2019; Willging et al., 2016) or inadequate consolidation of specific skills, particularly in relation to engaging with people with mental illness or AOD problems (Franke et al., 2010; King et al., 2009; Meehan et al., 2002; Olin et al., 2010; Simpson et al., 2014; Stewart et al., 2008; Willging et al., 2016). In some studies, trainees reported that training content was too condensed and emotionally intense (Gerry et al., 2011; Sanchez-Moscona & Eiroa-Orosa, 2021) or that they preferred greater emphasis on experiential learning or reflective exercises, and more feedback rather than theoretical content (Sanchez-Moscona & Eiroa-Orosa, 2021; Simpson et al., 2014; Stockmann et al., 2019).

Some studies explored trainees' perceived reservations about the training and subsequent workforce roles. Trainees expressed some uncertainty at training onset and others reported concerns related to feeling unprepared for the workforce roles (Atif et al., 2019; Hegedüs et al., 2016; King et al., 2009; Meehan et al., 2002; Stockmann et al., 2019; Tse et al., 2014; Willging et al., 2016). Barriers to participation in training were found to be ongoing life challenges including household and family commitments, personal/family crises, and difficulty with own personal circumstances related to mental health and AOD use (Atif et al., 2019; Colon, Deren, Guarino, Mino, & Kang, 2010; Cunningham, De La Rosa, Quinones, McGuffin, & Kutob, 2020; Deren et al., 2012; King et al., 2009; Weeks et al., 2006). Flexibility in delivery of training to cater for these barriers and enhance likelihood of continued engagement was recommended in studies (Colon et al., 2010; Treloar et al., 2012).

Personal Development

Studies also examined outcomes related to personal development. Trainees reported gaining insight into their own recovery through training (Blixen et al., 2015; Hegedüs et al., 2021; Hegedüs et al., 2016; King et al., 2009; Simpson et al., 2014; Toikko, 2016; Tse et al., 2014; Wolf, 2014), greater perception of self in regard to self-esteem, confidence, and self-efficacy (Blixen et al., 2015; Gerry et al., 2011; Hegedüs et al., 2021; King et al., 2009; Meehan et al., 2002; Simpson et al., 2014; Wolf, 2014) and improvement in health-related aspects such as psychosocial wellbeing and quality of life (Atif et al., 2019; Gammonley & Luken, 2001; Gerry et al., 2011; Joo et al., 2018; Stockmann et al., 2019; Weeks et al., 2006). Importantly, trainees reported greater insight into their own recovery (Blixen et al., 2015; Hegedüs et al., 2021; Hegedüs et al., 2016; King et al., 2009; Simpson et al., 2014; Toikko, 2016; Tse et al., 2014; Wolf, 2014).

Trainees also experienced interpersonal gains such as better relationships with peers and colleagues, increased respect from others, sense of empowerment, and perceived personal gain from helping others (Gerry et al., 2011; Rodriguez et al., 2011; Stockmann et al., 2019; Tse et al., 2014; Weeks et al., 2006; Willging et al., 2016).

Association Between Training Content and Outcomes

Several content topics were associated with positive outcomes. Training programs that included information and intervention/practice concepts were associated with enhanced professional development of knowledge and skills (Atif et al., 2019; Cleary et al., 2009; Crisanti et al., 2016; Hoagwood et al., 2018; Rodriguez et al., 2011; Stockmann et al., 2019; Weeks et al., 2006), personal development (Weeks et al., 2006; Wolf, 2014) and training satisfaction and perceptions of translational value to the workforce role (Cleary et al., 2009; Crisanti et al., 2016; Deren et al., 2012; Gammonley & Luken, 2001; Rodriguez et al., 2011; Stockmann et al., 2019; Weeks et al., 2006).

Inclusion of peer helping/peer advocacy principles in training was associated with increases in employment involvement and personal development (Franke et al., 2010; Gammonley & Luken, 2001; Gerry et al., 2011; Hegedüs et al., 2016; Horwitz et al., 2020; Simpson et al., 2014; Stockmann et al., 2019; Toikko, 2016; Tse et al., 2014; Wolf, 2014). Where content on professional behaviours was also included with peer helping and peer advocacy principles, studies found enhanced professional development and training satisfaction (Cronise et al., 2016; Franke et al., 2010; Horwitz et al., 2020; Sanchez-Moscona & Eiroa-Orosa, 2021; Simpson et al., 2014; Tse et al., 2014).

Where training content included communication skills, outcomes that were frequently observed were enhanced personal development (Gammonley & Luken, 2001; Gerry et al., 2011; Hegedüs et al., 2016; Meehan et al., 2002; Rodriguez et al., 2011; Weeks et al., 2006; Willging et al., 2016) and perceptions of translational value to the workforce role (Bentley, 2000; Gammonley & Luken, 2001; Rodriguez et al., 2011; Willging et al., 2016). Gains in professional development and high rates of training satisfaction were found when both communication and counselling skills were included in training (Bentley, 2000; Compton et al., 2014; Cronise et al., 2016; Hoagwood et al., 2018; Meehan et al., 2002; Willging et al., 2016; Wolfe et al., 2013).

Enhanced personal development outcomes were observed following training which included content on recovery concepts (Gerry et al., 2011; Stockmann et al., 2019; Tse et al., 2014), self-care and personal coping skills (Tse et al., 2014; Willging et al., 2016; Wolf, 2014), personal recovery (Gerry et al., 2011; Simpson et al., 2014; Tse et al., 2014), and illness/health behaviour (self-) management (Blixen et al., 2015; Weeks et al., 2006). Furthermore, training content relating to self-disclosure appeared to be associated with outcomes of improved peer support interactions and meaningful

and constructive use of their lived experience in their workplace (Stockmann et al., 2019; Toikko, 2016; Watson, Lambert, & Machin, 2016).

Patterns were also observed regarding perceived shortfalls of training associated with the absence of particular content topics in the training programs. For example, for training programs that did not include content on information or intervention/practice concepts, trainees reported difficulties directly interacting with peers, were unsure how to assist family members, or were in need of more opportunities to apply their skills (Franke et al., 2010; Sanchez-Moscona & Eiroa-Orosa, 2021; Simpson et al., 2014; Tse et al., 2014). Further, where training that did not include content on peer helping/peer advocacy principles, trainees felt underprepared when dealing with people experiencing severe problems or ill-equipped to handle diverse clients (King et al., 2009; Meehan et al., 2002; Tse et al., 2014; Willging et al., 2016). In addition, where content on professional behaviours was not included in training, trainees indicated that more attention was needed to help trainees with these skills, such as decision making and protecting personal boundaries (Olin et al., 2010; Willging et al., 2016).

With the absence of content on communication skills and counselling skills, some trainees felt unprepared to engage with clinical staff in relation to conversing with staff members and working collaboratively due to perceived lack of confidence and skill (Franke et al., 2010; Olin et al., 2010; Simpson et al., 2014; Tse et al., 2014; Weeks et al., 2006). In the absence of self-disclosure content, trainees reported struggling to effectively engage, connect with their peers, and required more guidance on how to meaningfully share their common experiences to motivate others in their recovery efforts (Meehan et al., 2002; Olin et al., 2010; Simpson et al., 2014; Tsai et al., 2017; Willging et al., 2016).

Conclusions

This rapid literature review identified 38 published papers that reported empirical data on training for lived and living experience workforces. Limitations in the identified papers were observed, including the heterogenous nature of study designs, which precluded specific patterns of findings and conclusions from being drawn. The identified papers also contained few studies of family/carer trainings and of trainings for the AOD sector and a low proportion of trainings were developed and / or delivered by people with lived experience. Additional research in these areas is needed to determine outcomes from training. Furthermore, inclusion of grey literature was outside the scope of the present review. Examination of unpublished reports or information from other sources may have yielded further information. Finally, and importantly, the training programs assessed in the eligible literature were also commonly intended to prepare trainees for a particular project role, such as delivery of a peer-led intervention within the context of a randomised controlled trial, rather than providing universal training to prepare attendees for general, ongoing workforce roles. Further research of these types of training programs is required to examine their benefits.

Despite these limitations, the findings from the literature review provide preliminary understanding of the components of training that are likely to be associated with beneficial outcomes for those who undertake training. These benefits were in relation to professional skill development, personal wellbeing, and ongoing educational or vocational engagement. Some limitations were also identified by trainees, particularly where follow-up support or supervision was unavailable, or where training left people feeling unprepared for a workforce role. Consequently, the findings from the literature review offer suggestions for ways in which training programs can incorporate particular content areas and teaching and learning methods to enhance the benefits of training for preparing trainees to undertake lived and living experience workforce roles. These include design and delivery of

training by people with lived experience, provision of ongoing supervision following completion of training, the need for organisations to be prepared and accepting of lived and living experience workforce roles, and skill-based training to enhance applicability of training content to work roles. Attention to these components indicates strong potential for best-practice training for these cohorts.

Table 1

Sample, Study Characteristics, Training Content, and Findings from Included Quantitative Studies

Study (Year) Country	N (% female) Mean Age (SD)	Population; position level (consumer/ carer)	Training Purpose/Type (Role)/Duration (Total Hrs)	Training Content	Relevant Findings
Bentley (2000) USA	15 Gender and age not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Current (NA) 6 x 3 hrs workshops over 10 weeks (18 hrs)	Content: 1. Organisational and leadership skills - basic communication skills; setting and prioritising goals; decision making; task-centred planning 2. Peer counselling - roles, responsibilities and rewards, values-oriented approach to counselling, listening skills, problem solving steps/strategies; 3. Referrals - defining a "good" referral; preparing a peer for a referral; making connections (linking, cementing, monitoring); developing and cultivating relationships with community leaders and providers 4. Group facilitating - starting a group (goals and purpose, recruitment and orientation, codes of behaviour, building community); running a group (group dynamics, keeping it going); ending a group (managing feelings, evaluating change) 5. Needs assessment - what, why and when (re planning); process steps; purpose and resources, identifying needed information and determining availability, collecting information and data, preparing a report 6. Building self-direction and self-esteem - personal coping skills; managing criticism and fear; building self-esteem; practicing assertiveness Methods: brief didactic presentations; interactive discussion of life experiences; hands on exercises	Post-training: Most agreed that instructor cared about their learning and development; instructor tried to connect workshop content to their daily experience; instructor had encouraged discussion and questions; they were stimulated and challenged by material; increased their skills; they had learned things they could use. Written feedback: sessions were not too heavy, suitable deliver pace, appropriate sharing with others, relaxed style of teaching and hands-on exercises; suggestions for more training. 6-month follow-up: Communications skills used frequently and counselling skills often. Reflective listening, open questions, eye-contact, problem-solving reported as most useful things learned. Content on self-esteem highly valued, case management and needs assessment content used occasionally/rarely. Most satisfied with training.
Cleary (2009) Australia	Sample size not reported (66% female) M_{age} = 43 (10.7)	Dual diagnosis - substance use in people with mental illness) (Consumer)	Training consumers as PSWs Current (paid) 5 hr training	Content: prevalence of substance misuse, reasons for substance misuse, symptoms that suggest a client may be misusing substances, major current therapeutic treatment approaches, referral services, management strategies Methods: structured presentations, a range of interactive group exercises to facilitate in-depth discussion	Post-training: Enhanced perceptions that adverse life circumstances responsible for problematic drug use; extent of feeling sympathetic toward people using drugs; and in perceptions of extent to which people who use drugs are entitled to a higher level of health care than people who do not use drugs Majority found program interesting/very interesting; useful/very useful; program increased knowledge/understanding; many noted that the program influenced the way they thought about people using substances; all thought program well organised;

					most satisfied/ very satisfied with the program and would recommend
Compton (2013) USA	14 Gender and age not reported	Mental health; entry level (Consumer)	Training consumers as PSWs NA (NA) 5-day training	Content: 1. Orientation - confidentiality, therapeutic boundaries, employee code of conduct, de-escalation and emergency procedures, person-centred care delivery, risk management and incident reporting, clients' rights, and cultural competence; 2. Core topics - recovery paradigm, whole health, and resiliency, meaningful day, adequate treatment, safe housing, and technology; "Passport to recovery" concept re plan for unfolding of recovery roadmap and who should be involved in recovery process. Creating environments and relationships that promote recovery, effective listening and the art of asking questions, and person-centred planning; 3. In-service trainings, such as site visits (local treatment services; Crisis Intervention Team)	Statistically significant improvements in pertinent knowledge, self-efficacy for working in a community navigation role.
Crisanti (2016) USA	37 (49% female)Age not reported	Mental health and AOD; Entry and mid-level	Training consumers as PSWs Not reported (not reported) 1-day training	Content: 1. Review current understanding of evidence-based treatment of trauma and/or substance abuse; (2) Increase empathy and understanding of trauma and substance abuse; 3. Describe training program, Seeking Safety (SS); 4. Provide assessment and treatment resources; and (5) identify how to apply SS for specific populations. Methods: Opportunities for trainees to discuss implementation issues and conduct experiential learning exercises, including role-play of a full SS session.	PSWs and BHPs reported high satisfaction and comfort, PSWs benefited from training to the same extent as BHPs. Compared to BHPs, PSWs reported greater improvement in counselling ability.
Cronise (2016) USA	597 (64.8% female) Age not reported	Mental health (level and consumer/carer training not stated)	Training consumers as PSWs Current (paid) 20-80 hrs of training	Content (identified from survey): 1. Peer relationship: skills and knowledge of active listening, interpersonal skills, dealing with boundaries (96.7% of respondents had received training that covered this domain); 2. Direct peer support: skills and knowledge on "telling your recovery story,"; tasks involved in intentional peer support, peer bridging, peer counseling, facilitating groups, group dynamics, peer advocacy, dealing with difficult situations, cultural competency, cultural self-awareness, and person-centered planning (95.6% received); 3. Policy, legislation, advocacy and rights protection (94.7% received); 4. Recovery concepts and categories;	Most felt training amount sufficient to complete job. Most agreed/strongly agreed they have job responsibilities that reflect their training and lived experience. Most reported having to complete continuing education (e.g., conferences, workshops, webinars). 29% reported receiving 20-40 hr per year.

				principles of recovery, self-care, self-determination, the stages of recovery, and wellness recovery action plan (93.3% received); 5. Traditional mental health and rehabilitation services: addictions, motivational interviewing, mental health first aid, medications, case management, DSM diagnoses, individual placement and support (92.0% received); 6. Administrative, supervision, and workplace-related; co-supervision, computer skills, work ethics, role of the peer provider, and time management (89.3% received); 7. Alternative healing and wellness (76.3% received); 8. Precrisis and crisis support (65.9% received)	
Cunningham (2020) USA	575 (62.6% female) Age not reported	Mental health; entry level (Not stated)	Training consumers as PSWs NA (NA) 80 hrs across 4 weeks	Content: 1. Foundations of recovery; 2. Practical aspects of employment in peer support such as tools for entering the workforce, empathy, motivational interviewing, ethics/boundaries, and documentation/HIPAA compliance; 3. Integrated health care, selected laboratory skills (e.g., measuring blood pressure and blood glucose), clinic operations, and the association between behavioural health and morbidity/mortality	Dropout for trainees with psychiatric disability and mental-illness-only were 25.1% and 17.4%. Of trainees with psychiatric disability, dropout was substantially greater among men than women. Dropout greater among men with psychiatric disability than men with mental illness only. In contrast, dropout was similar for women with psychiatric disability and mental illness only, and dropout was comparable among men and women with mental illness only.
Gammonley (2001) USA	30 (56.7% female) M_{age} = 39.3 SD not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Future (volunteer) 2 hr weekly training over 6 months (30 hrs)	Content: 1. Peer helping and peer advocacy principles, role of recreation in rehabilitation and recovery, introduction to advocacy and communication skills, utilizing personal strengths as an advocate; 2. Listening skills, conducting interviews, making presentations, letter writing, telephone use, leading discussion groups, gathering community resources, designing surveys and flyers, recreation and activity planning, job description development; 3. article writing, public education, developing special projects, state and local advocacy groups, Americans with Disabilities Act Methods: Welcomes and announcements; homework review; introduction of new learning topics; role-play illustration of targeted skills; introduction of homework assignment; small group work for skill practice; wrap-up activity	Advocacy skills: Significant increase in making phone calls to inquire about community resources overtime, and significant reduction in frequency of "discussing accommodation needs with a provider" from baseline to post-training; return to baseline level at 6-month follow-up. Quality of life: Significant improvement in satisfaction with total subjective quality of life and on four separate items (the way you spend your spare time; how you get along with people; the chance you have to do important/interesting things; how comfortable you feel with people). Educational and employment: Significant improvement in educational or employment involvement.
Hegedüs (2021)		Mental health; entry level (Consumer)	Training consumers as	Content: 1. Promoting health and well-being; 2. Trialogue; 3. Empowerment in theory and practice;	Personal recovery, hope, introspection, stigma resistance and self-efficacy significantly increased during the training (except

Switzerland, Germany			PSWs Future (any capacity) 1.5 years	4. Experience and participation; 5. Perspectives and experiences of recovery; 6. Independent peer advocacy; 7. Self-exploration; 8. Recovery-based assessment and planning for people in crisis; 9. Peer support; 10. Teaching. Methods: 40 hours plus 150 hours practical training in the field	for mental health-related quality of life). Employment (post-training) significantly increased. Having a main income from any employment did not change significantly between t1 and t2. From t1 t2, those who had an income as a PSW slightly increased. Participants whose last inpatient stay was 0–1 year before training showed significant lower stigma, and self-efficacy at t1 than participants with 2+ years since the last inpatient stay.
Hoagwood (2018) USA	318 (95% female) M_{age} = 45.8(9.7)	Mental health; entry level (Carer)	Training for family peer advocates Future (any capacity) 40 hrs in-person group & 12 x 1 hr follow-up calls (52 hrs)	Content: 1. Skills for developing effective working relationships with families, assessing family needs, and strategies for activating families to address their children's mental health needs; 2. Knowledge about childhood mental disorders, the diagnostic process, evidence-based treatments, and service options.	Knowledge and mental health service self-efficacy scores were significantly higher post-training.
Horwitz (2020) USA	444 (140 web; 304, in-person) Gender and age not reported	Mental health; entry/mid level (Carer)	Training for FPA Future and current roles (paid) 14 x 1 hr online modules & 5 day in-peson course	Content: 1. Family Peer Support Services and the Family Peer Advocate Role; 2. Family Driven Care; 3. The Power of Lived Experience; 4. Embracing Each Family's Culture; 5. Effective Communication Skills for Family Peer Advocates; 6. Engagement Strategies for Family Peer Advocates; 7. Learning About Families: Exploring Strengths, Needs and Culture; 8. Creating a Plan to Support Families; 9. Empowerment Strategies for Family Peer Advocates; 10. Developing Effective Partnerships; 11. Recognizing and Responding to Crisis and Safety Concerns; 12. Professionalism: Code of Ethics, Confidentiality, Boundaries; 13. Education; 14. Children's Mental Health Services	Web-based and in-person training: Post-test knowledge level significantly higher than pre-training knowledge level. Other: No significant difference between in-person and online knowledge gains. Significant differences in employment characteristics between completers and non-completers, including work status as an FPA and whether their employer requires credentialing as an FPA.
Joo (2018) USA	3 (69 peer-client meeting recordings coded and analysed) (100% female) All participants ≥ 50 years	Mental health; entry level (Consumer)	Training consumers as peer mentors Current (volunteer) 20 hours & 8 week field	Not specified	Post training examination of audio recordings of peer-client meetings: Peers used many skills taught in training (e.g., client-centred talk, positive rapport building, emotional responsiveness). Client-centred communication and positive rapport associated with increased working alliance and decreased depressive symptoms. Post training: 1) Peers talked more than clients consistently over study period; 2) Peer talk focussed predominantly on building rapport, emotional support,

			training (supervised)		facilitating talk with clients, and providing information and counselling; 3) Peer self-disclosure was used frequently in emotionally responsive talk; 4) Positive global affect was consistently high across all meetings; 5) Degree of client-centred talk increased; 6) Rapport building decreased over time; 7) Counselling skills taught in training used more in first session than later sessions
Olin (2010) USA	15 Gender not reported M_{age} = 42.8 (10.3)	Mental health; entry level (Consumer)	Training consumers as PSWs Current (not reported) 10 weekly 4 hr sessions & 6 monthly boosters session (40 hrs)	Content: 1. Essential engagement and community skills; 2. Priority setting and problem-solving skills; 3. Group management skills; 4. Understanding psychiatric disorders, the diagnostic process and treatments for children; 5. The mental health system; 6. Service options through the education system. 7. Post-training monthly meetings for 6-months to follow-up on special topics of interest	Training did not significantly change knowledge level. Training impacted perceptions of professional skills (i.e., it did not influence basic advocacy skills (e.g., engagement, listening and boundary setting) but had a significant impact on complex skills (e.g., priority setting, problem solving, group management, application of knowledge about child mental health disorders and treatment, the mental health care system of care, and service options through the education system). Training significantly improved mental health service efficacy.
Rapp (2008) USA	78 Gender and age not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Future (paid) 15 weekly 3 hrs session & 7-week 104 hr intern (149 hrs)	Content: Basic helping skills, theory and skills of strengths-oriented practice, recovery and wellness, cultural competence, documentation, confidentiality, and ethics. Methods: Active learning; discussions, experiential exercises, reading assignments, role-play; didactic presentations. Instructors meet with individual students at least once a month to offer support and feedback	Graduates had statistically significant increases in employment and post-secondary education enrolment at all three follow-up points. Students working in social services jobs increased post-training. Percentage of employed students working hours per week also increased, with steady growth in number of students working more than 30 hours per week throughout the study period. Employed graduates worked more days during the six-month survey period after completing the program.
Rodriguez (2011) USA	58 Gender and age not reported	Mental health; mixed levels of experience/expertise. Some FPA "were generally more experienced professional peers" compared to others. (Carer)	Trained family peer advocates Current (not reported) 40 hrs & bi-weekly 1 hr consultation calls for 6 months (88 hrs)	Content: 1. Conceptual framework; overarching framework of Parent Engagement and Empowerment Program (PEP), principles of parent support, behaviour activation; 2. Listening, Engagement, and Boundary Setting; 3. Priority Setting, Developing an Action Plan, and Problem Solving; 4. Group Management Skills; 5. The Mental Health System: Preparing Parents to Navigate the System; 6. Specific Disorders and their Treatment; 7. Service Options through the School System Skills Methods: adult learning approaches; direct instruction to share knowledge or techniques for practice, group support, modelling, vicarious	Significant increases in family empowerment, mental health services efficacy, and skills post-training, and at 6-month follow-up. Key FPA activities used: Emotional support and service access issues, especially involving the education system. FPAs reported increase in activities (e.g., priority setting, role-playing to help develop parent skills, and providing parents support around service access).

				learning, and practice opportunities (role rehearsals) with feedback	
Stoneking (2007) USA	68 Gender and age not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Future (paid) 7 day training & 12 weekly 2 hr practicums	Content: Introduction to recovery principles and wellness management; 1. Recovery: the vision; 2. Developing a support system; 3. Self-help strategies; 4. Healthy lifestyle; 5. Building self-esteem; 6. Enhancing wellness; 7. Beginning your personal journey of recovery; 8. Developing your recovery plan Methods: Warm-up exercise and guided five-to-eight-minute mindfulness meditation exercises for relaxation and focus; intensive didactic (lecture and panel presentations accompanied by PowerPoint, videotape and overhead transparencies, homework assigned and reviewed the following day) and experiential training (role plays, observing, sharing personal experiences, providing feedback and small group exercises followed by group discussion)	Post-training improvements: Knowledge, skills, attitudes. Knowledge and skills emphasized at training improved when applied in work settings after three months of trainees being employed.
Tsai (2017) USA	14 (14.3%) M_{age} = 45.54 (11.84)	Mental health; entry level (Consumer)	Training consumers as PSWs Not reported (not reported) 2-day workshop & 2 monthly booster sessions	Content: 1. Understanding the mindset in which MI is delivered, four main processes of MI (engage, focus, evoke, plan), and common components of MI used to build an empathic, client-centred relationship (e.g., open questions, affirmations, reflections, supporting autonomy); 2. Elicit motivations for change, resolving ambivalence toward change, and strengthening commitment to a change plan (e.g., asking questions that pull for arguments for change, reflectively emphasizing the client's change-supportive statements) Methods: Experiential and interactive learning, live and video demonstrations of MI sessions, and practice opportunities to build MI skills; booster sessions to review MI principles and practices, discussing issues that peer specialists encountered and providing group feedback and coaching activities	Post-training participants had significant decline in MI Inconsistent Adherence, indicating reduction in the use of strategies antithetical to MI (i.e., they showed reductions in providing Unsolicited Advice and Emphasizing Absolute Abstinence). Significant decline in the Sharing Lived Experience Adherence so peer specialists shared common experiences with service recipients less often over time. No significant changes on adherence or competence related to MI Fundamental and Advance MI subscales.
Wolf (2014) USA	112 (30 telephone survey; 54 mail survey; 28 in-person interviews)	Mental health; entry level (Consumer)	Train PSWs Future (paid) Full-time over 2 semesters	Content: 1. Introduction to Mental Health Systems - systems and services for children, youth, and adults with serious mental health and substance-use conditions. Topics included treatment, rehabilitation and recovery, community support services, consumer empowerment, and career opportunities.	1. Recovery/Health outcomes: Most reported significant ongoing life challenges. Most employed peers felt good about helping others, increased self-esteem, made progress in own recovery, increased understanding of own disorder, were satisfied with earning income, and many had a positive impact on career.

	(63% female telephone survey; 63% female mail survey; 57% female in-person interviews) Age not reported			Contemporary articles, primary materials, and texts were supplemented by practitioner guest lecturers who brought real-world experience into the classroom. 2. Topics in Mental Health - conceptual knowledge and hands-on clinical and administrative skills. Subjects included terminology, assessment and documentation, diagnosis, multicultural competence, dual diagnosis, psychiatric medications, treatment, relapse prevention, crisis management and suicide, anger management, violence prevention, stress management and burnout, rehabilitation, goal planning and writing, entitlements, and budgeting. 3. Practicum in Mental Health - 150-hour internship in a community agency with regular supervision, written work, and a monthly on-campus seminar. The practicum integrated experiential learning and classroom-taught knowledge, skills, and attitudes.	Comparing outcomes between peers and non-peers: 2. Education: More non-peers had earned a higher degree and were pursuing higher degrees in mental health fields post-training compared with peers. 3. Employment: Employment higher among nonpeer graduates than peers. Graduate respondents were employed by more than 20 area mental health agencies. Though lower than nonpeers, high rate of peer graduates employed in the field and earning degrees or seeking additional higher education. High employment rates among all graduates, with a majority of working full-time. 4. Earnings: Percentage of peers earning salaries in the $30,000–$34,000 range was comparable with nonpeer graduates. More nonpeers were earning $15,000 to $30,000 compared with peers. Peer graduates were overrepresented in the lowest earnings category.
Wolfe (2013) USA	4 (25% female) Age range: 54-69 Mean age not reported	AOD; entry level (Consumer)	Training consumers as PSW Future (NA) 2-day group sessions, weekly 1.5 hr group sessions, weekly 45 min individual sessions) over 4 months (40 hrs)	Content: MI spirit - concepts of empathy, showing respect, taking a collaborative stance, demonstrating acceptance, and eliciting the point of view of the participant; Introduction of specific MI skills including delivering personal feedback, eliciting, and amplifying ‘‘change talk,’’ and asking open-ended questions, affirmations, reflective statements, and summaries. Global MI constructs - evocation, collaboration and autonomy/support, direction and empathy; client-centred skills (open-ended questions, reflections, affirmations, problem identification and rolling with resistance), and identification and reinforcement of change talk (emphasizing personal change, eliciting pros and cons of change, heightening discrepancies, and providing appropriate summaries). Methods: didactic instruction, group workshops, individual feedback sessions, role play with verbal feedback on strengths and weaknesses in MI practice, video demonstrations.	Trainees did well in the MI styles and strategies assessing/highlighting motivation to change, affirmation and support for change, and change planning. They had difficulty in the authority (telling patient what to do), pros and cons, giving advice, and open-ended questions. MITI ratings post-training: half of peers achieved treatment fidelity with increases in all global constructs (MI spirit, direction and, particularly empathy - ability to take another’s perspective). 1 peer did not reach fidelity on direction (difficulty maintaining focus on targeted behaviour) and 1 peer did not reach fidelity on Empathy (difficulty understanding client’s perspective). All achieved competence in MI Spirit. (e.g., respectful, non-judgmental working relationship with clients (collaboration); highlighted client’s concerns, hopes, and perspective (evocation); and respected the client’s decisions (autonomy/support).

Table 2

Sample, Study Characteristics, Training Content, and Findings from Included Mixed-Methods Studies

Study (Year) Country	N (% female) Mean Age (SD)	Population; position level (consumer/ carer)	Training Purpose/Type (Role)/Duration (Total Hrs)	Training Content	Relevant Findings
Atif (2019) Pakistan	45 (100% female) M_{age} = 30 (5.7)	Mental health; entry level (Consumer)	Training consumers as PSWs Future (volunteer) 5 days of training (30 hrs)	Content: (a) psychosocial factors impacting mother and child health during the perinatal period, (b) counselling skills, (c) intervention principles, contents and delivery mechanisms. Methods: lectures, discussions and activities, use of case scenarios, sharing personal experiences and role-plays (focused on counselling skills, skills to engage mothers and their families during session delivery and dealing with challenging situations). The role-plays assessed peer volunteers' ability to deliver intervention. The intervention material consisting of the THPP reference manual and job-aids was given to the peer volunteers to assist them in the delivery of the intervention. Field training (working with a consumer for 3 months) after training	Quantitative: Most maintained or improved level of competencies at initial assessment and at follow-up. All participants reached satisfactory competency levels. Qualitative: Training facilitators themes: 1. ability to relate to trainers, 2, perceived usefulness of the training, 3. training techniques, 4. linkage with primary health care system, 5. increased psychosocial awareness and wellbeing Training barrier themes: 1. lack of refresher trainings, 2. household commitments 3. Fears linked to no prior training exposure
Deren (2012) USA	158 (80 experimental; 78 control) (24% female experimental; 36% female control) M_{age} = 40.8 (8.8) experimental M_{age} = 42.3 (8.9) control	AOD; entry level (Consumer)	Trained consumers as POW outreach workers Future role (paid) 4-5 day training & 12 weeks of supervised outreach	Content and Methods: Information on the rationale for the project, an overview of HIV and HCV facts, discussion of outreach strategies, role plays for conducting outreach, a practice outreach event and 12 weeks of supervised outreach. Post-training supervised outreach (12 weeks) in pairs with weekly supervision where activities were reviewed and planned	1.Most patients that began training completed it; 2. Life crises were not uncommon, which often took priority over training. 3. Qualitative: patients received many benefits from the outreach experience. 4. Most who completed intervention and conducted outreach were less involved in drug use and injections. 5. Drug use and sex risk behaviours of patients in the Experimental condition were not impacted during the follow-up period. 6. Patients in the Experimental condition who conducted outreach were significantly more likely to talk with others about HIV after the training and outreach intervention was completed. 7. Those who conducted outreach activities were more positive about their role as Health Educators and engaged in additional vocational activities. Recommendations: 1. More flexibility in training dates to increase participation and completion. Possibility of rolling admissions and other methods so that individuals can make up missed sessions; 2. Increased support to those who continue to use drugs, to assist them in maximizing training opportunities.

Franke (2010) Australia	50 (survey) 132 (interviews) Gender and age not reported	Mental health, Entry and mid level (Consumer)	Training consumers as PSWs Future & current roles (paid) Info session, 6-day intro, & Cert III in Community Services Mental Health course.	IPW content: Peer work roles, boundaries, sharing your story, self-management, and job opportunities. Certificate III content not described	Survey: Most (>90%) found training topics fairly/very useful, most (88%) were very interested in pursuing PSW role and Certificate III course. Interviews: Employment (volunteer & paid) and workforce participation increased among course completers over two years follow-up.
Hegedüs (2016) Switzerland	34 (survey – n = 16 sample 1; n = 18 sample 2) 10 (interviews) (72.2% female sample 1; 75% female sample 2) M_{age} = 47.5 (7.9) sample 1 M_{age} = 43.7 (8.9) sample 2 Gender and age not reported for interview sample	Mental health; entry level (Consumer)	Training consumers as PSWs Future (any capacity) 1 year (coursework classes [10x3 day sessions held monthly] and 2 practical trainings)	Content: 1. Promoting health and well-being; 2. Trialogue; 3. Empowerment in theory and practice; 4. Experience and participation; 5. Perspectives and experiences of recovery; 6. Independent peer advocacy; 7. Self-exploration; 8. Recovery-based assessment and planning for people in crisis; 9. Peer support; 10. Teaching Methods: 40 hours of practical training at an in- or outpatient unit of a mental health service (after first five training modules); practical training of 150 hours at psychiatric units or related areas such as teaching, projects, or advocacy.	Employment: At one-year follow up, most participants were employed as PSWs Training satisfaction (survey): Most very satisfied/satisfied with their employment status 1-year post-training. Post-training experiences (interviews): Reported a benefit concerning their personal and professional development but did struggle with 1) Evolving from the patient role despite experiencing the effects or consequences of mental illness; 2) feeling welcome and being confronted with conflicting expectations; 3) Helping others while being needy; 4) doing something worthwhile and the fear of failure.
Meehan (2002) Australia	10 (80% female) Age range: 21-60 Mean age and SD not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Future (any capacity) 16 week (4 week classroom & 12 week experiential)	Content covered: 1. Basic legal and ethical principles governing inpatient treatment; mental health act, mental health review tribunal, official visitors, patient rights; 2. Mental illness overview; history, treatment, symptoms; 3. Communication and counselling skills; reflective listening, self-advocacy, assertiveness, conflict resolution. Methods: Lectures, group work, role plays; practical/experiential training working with staff and inpatients at ward level; 4 hours per week for 4 weeks in acute, rehabilitation and activities areas, working in pairs for mutual support. Prior to ward sessions, trainees checked in to discuss issues of concern, and facilitators informally assessed their wellbeing. Debriefing sessions post-ward sessions to discuss matters not covered in lectures, and to develop strategies for unforeseen events	Focus group findings: Trainees generally satisfied with the format, content, relevance of program. Contents could have included more counselling, patient rights, patient advocacy, and legal issues around regulating patients in hospital. Trainees appreciated interacting with staff and patients on the ward - some found this difficult especially in the more disturbed wards as it brought back memories of own problems. Trainees recognized the difference in the relationship between professional staff and patients, and their relationship with patients (e.g., patients tend to disclose more when they realise that trainees are there to help them). Trainee's lack of a clear job description created some problems for project participants at ward level. Trainees felt somewhat insecure when questioned by staff in the wards about their role. Questionnaire data: State anxiety, Trait anxiety, Perceived stress, and Locus of control either increased or maintained overtime but these changes were non-significant. Self-esteem significantly improved overtime.

Tse (2014) Hong Kong	25 Gender and age not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Future (paid) 6 weeks coursework (10x3hr + 1 day workshop) & 24-week paid internship	Content: 1. Reconstructing an individual's own personal recovery account; 2. The recovery concept; 3. The peer support concept; 4. Helping skills; 5. Goal setting; 6. Professional codes of conduct; 7. Working relationships with users; 8. Crisis management; 9. Seeking supervision and self-care On-the-job training: 1. Individual supervision from a social worker to provide feedback on performance and assistance with filling forms/procedural requirements; 2. Group supervision co-facilitated by social workers and the programme consultant every four to six weeks encouraged trainees to share their concerns during such sessions and to brainstorm solutions.	Survey responses: *Psychosocial measures*: Trainees scored higher on Recovery and Hope at post-training than baseline (not tested for statistical significance). Scores for self-esteem were similar at baseline and post-training. *Training experience*: Trainees had positive experience of training (i.e., they held the course trainers in high regard, and would recommend the program). *Overall assessment* (text responses: 5 themes emerged): 1. Positive gains (Trainees turned their illness into a 'strength', time was better utilised and mood improved. Training prompted them to reach out more to the community and made them realise that they could achieve other things). 2. Factors that helped trainees to deal with their new role (Support from other trainees, supervisors, families and the satisfaction from helping service users were important motivators). 3. Challenging aspects of being a PSW (For some, initially engaging with service users was daunting but this lessened. Day-to-day tasks were also seen as challenges (e.g., conversing with different people and filling paperwork). 4. Uniqueness of the program (empathetic and empowering environment). 5. Expectations – envisioning a future career (Majority wanted to continue to work as PSWs and felt prepared for the role).
Weeks (2006) USA	130 (36.2% female) M_{age} = 39.8 (7.37)	AOD; entry level (Consumer)	Trained PSWs Future (not reported) 10 sessions (5x 2-hour sessions, 5 field sessions)	Content: 1. Introductions, concepts of the program (advocacy, harm reduction), community concerns; risks and solutions role play; 2. Basic HIV/STI/TB risk and prevention information; persuasive communication techniques and role play, demonstrate use of harm reduction materials, homework; 3. Review public health advocate (PHA) intervention; basic hepatitis risk/transmission information, model harm reduction with materials/information, practice contact documentation, role play "full intervention engagements", identify public advocacy activity; 4. Role play difficult situations; develop action plan for first street/site activity; review/role play expected scenarios, hand out materials for implementation; 5. Implement RAP harm reduction/health advocacy intervention in community sites; return to offices for feedback/sharing; 6. Staff/PHA partners conduct RAP harm reduction/health advocacy in drug use sites or gathering places; document contacts	Qualitative: Intervention is feasible and appropriate. PHA's modelled protective behaviours, distributed prevention materials, and encouraged the adoption of healthier and safer activities. Many hoped their work as PHA could someday become a steady, paying job. Most increased their self-worth from helping others despite ongoing struggles; improved their own health and well-being; felt more respected by their peers and community members; and improved their perception of self; Few had negative experiences (some difficulties included negative responses from others they approached); 6. Personal barriers to conducting PHA work (e.g., homelessness, distractions from addiction, problems with police). Quantitative: Prevention Practices (Changes from Pre-Post training) - There were significant increases in PHAs' use of condoms, reductions in sex partners, increases in cooking of drug solutions by injectors, use of rubber tips by crack users, reduction in drug use overall, and increase in PHAs who reported having spoken to other drug users in the last 30 days about HIV prevention or other health issues and harm reduction. Other harm reduction practices for injection drug users also increased, but these were non-significant (e.g., Reduced

		Methods: didactic education; demonstration of prevention or harm reduction practices; provision of materials for risk prevention and harm reduction; monthly community advocacy group meetings for ongoing opportunity to get together to plan and implement community advocacy action, share experiences conducting harm reduction and health advocacy with other PHAs, socialize in a safe environment, and to voice their concerns.	syringe sharing, more selective about injection partners, stopped sharing syringes). Participants' attitudes toward the concept and practice of conducting PHA work (PHA attitudinal index) significantly improved from intake to post-training.

Table 3

Sample, Study Characteristics, Training Content, and Findings from Included Qualitative Studies

Study (Year) Country	N (% female) Mean Age (SD)	Population; position level (consumer/ carer)	Training Purpose/Type (Role)/Duration (Total Hrs)	Training Content	Relevant Findings
Blixen (2015) USA	8 (62.5% female) Age range: 45 – 64 (*Md* = 56)	Mental health; entry level (Consumer)	Training consumers as PSWs Future (not reported) 2-days group training and participation in 12 educational sessions	Content: orientation/introduction, detailed coverage of the TTIM intervention, communication skills, group leading/co-leading, assistance with help-seeking pathways and crisis management, illness self-management including physical and mental health support needs, Methods: involved role-play; participating in TTIM nurse-led intervention sessions, as facilitators first then co-leaders (second component of training)	Themes: 1. Positive group experience; 2. Success with the training manual; 3. Increased knowledge of mental illness/diabetes; 4. Improved self-management of own mental illness/diabetes; 5. Increased self-confidence; 6. United in purpose
Colon (2010) USA	80 (34% female) M_{age} = 40.8 (8.8)	AOD; entry level (Consumer and family)	Training consumers as peer outreach workers Not reported (paid) 5-day training, 12 weeks of supervised peer outreach & 2 monthly booster sessions	Content and Methods: 1. Training overview; review of intervention components; discussion of training goals and rationale for the focus on migrants from Puerto Rico; 2: Overview of outreach and HIV/HCV (Hepatitis C virus) facts; 3: Discussion of outreach strategies and available resources; role plays to practice outreach skills; 4: Further discussion of outreach; preparation of outreach kits (pamphlets, condoms, etc.) for distribution while conducting outreach; 5: Field event: Conducting outreach in the community; discussion of experiences; closing ceremony, certificates of completion; 6. Clinic staff and trainee discussion sharing learnings from training and during outreach	Benefits: Improvement in pertinent knowledge, self-efficacy for working in a community navigation role. Harm reduction approach perceived to increase retention of trainees in program. Challenges: Attending training under influence of drugs and attending all training sessions. Limitations: A need to assist trainees to transition to other peer educator roles Recommendations: Flexibility in training offerings; need for post-training/project support; counselling support for dealing with stressors of the peer outreach role and work through ongoing drug and mental health issues; support for interpersonal issues. Support required to help trainees utilise and develop skills to transition to other roles post training.
Gerry (2011) UK	17 Gender and age not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Future role (not reported) 2-week training	Content: 1. Recovery. 2. The power of peer support. 3. Self-esteem and self-talk. 4. Meaning and purpose. 5. Telling your personal story. 6. Communication. 7. Employment as a path to recovery. 8. Being with people in challenging situations. 9. Peer support in action.	Training benefits: Increased confidence and capacity of inter- and intrapersonal skills; personal growth, increased self-esteem & confidence, feeling empowered & hopeful, improved life quality. Training limitations: training exhausting & intense Recommendations: training run over a longer time period. Post-training challenges: lack of involvement in professional growth immediately after the training impeded initial attainment of career goals; trainees perceived the trust's uptake of the recovery approach to be 'tokenistic'.
King (2009) Australia	12 (58.3% female)	Mental health; entry	Training consumers as	Not specified	Themes were reported in terms of frequency (Typical = appeared in 6-7 transcripts; General = 4-6 transcripts; Variant = 2-4 transcripts).

	M_{age} = 37.5 (13.3)	level (Consumer)	peer outreach workers Current (volunteer) Not reported		Domain 1: *Core idea 1: 'experience of the training'*: Typical = Theme 1 – found the training beneficial; Theme 2 – prepared using own past experience/program resources. Variant = Theme 3 – inadequately prepared. Core idea 2: '*Experience of supports available/utilised'*: Typical = Theme 1 – fellow peer outreach volunteers as supports; Theme 2 – program staff as supports. Variant = Theme 3 – need more formal support; Theme 4 – Need for training in specific skills. Domain 2: Core idea 1: '*perceived benefits to self*': General = Theme 1 – skill improvement. Typical = Theme 2 – personal reward from helping others; Theme 3 – greater confidence and self-worth. Variant = Theme 4 – ability to relate to people; Theme 5 – insight into own health and recovery. Core idea 2: '*challenging aspects of outreach work'*: Typical = Theme 1 – being reminded of past relapses; Theme 4 – talking with outreach recipients who are very unwell or uninterested. Variant = Theme 2 – perceived lack of status and skill compared to healthcare professionals; Theme 3 – taking the issues of outreach recipients' home; Theme 5 – difficulty communicating/managing own psychiatric disability.
Sanchez-Moscona (2021) Spain	16 Gender and age not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Future role (not reported) Not reported	Content: 1. Pedagogy applied to peer support training and to recovery, group dynamics; 2. Basic concepts of peer support, accompaniament and mutual aid groups, rights, language and communication, risks and limits; 3. The agenda in the Catalan mental health system, comparison of training models Methods: participatory methodology, role-playing, debate, discussion	Training content benefits: Learning theories, teamwork, practical exercises. Content was appropriate and was taught respectfully, encouraging learning. Trainees valued the understanding, confidence, skills, and knowledge acquired. Through practical exercises, trainees developed critical reasoning and joint learning construction. Learning objectives for each session were achieved by most. Training content limitations: Theory heavy, too little practical content, training intense due to large amount of information. Suggested more general training elements be added e.g., access requirements, pedagogical methodology to assimilate theoretical content.
Simpson (2014) UK	13 (30.8% female) M_{age} = 42 (6.71)	Mental health; entry level (Consumer)	Training consumers as PSWs Future (any capacity) 12 weekly 6 hrs sessions (72 hrs)	Content: 1. Exploring peer support; 2. Tree of life; 3. Recovery and personal recovery plans; 4. Recovery and personal recovery plans (continued); 5. Confidentiality, information sharing, exploring boundaries; 6. Active listening skills; 7. Social inclusion; 8. Appreciating differences; 9. Responding to distressing situations; 10. Revisiting boundaries and difficult situations—participants' choice; 11. Preparing to be a peer supporter; 12. Endings and celebrations Methods: Tree of life narrative sharing about their lives; consideration of objectives of each session, participants' individual personalities, sensitivity of the information under discussion, and direct requests from the group	No change in trainee's experiences and feelings post-training. In general, training a positive experience that provided them with good preparation for PSW working (e.g., increase self-esteem, confidence, pride, capacity to overcome challenges) Useful training components: Supervision/support, role-plays, support groups. Training issues/limitations: Training could not cover all content, insufficient preparation for emotional reaction, no family-specific training, desire for more practical training.

				determined choice of delivery method; small to large group work to bring ideas together, encourage listening and less confident members of the group to feel comfortable sharing their experiences; role-playing and fictitious written scenarios to experience "real-life" situations and group discussion of differing approaches and options. Post-training support and supervision	
Stockmann (2019) UK	56 Gender and age not reported	Mental health; Multiple professions and positions were represented (Consumer)	Training consumers as PSWs Current role (not reported) 4 weekly sessions over 1 year	Content: 1. Introduction to the course, family therapy, OD and self-work (history of systemic practice; social constructionism and the importance of context; OD as approach and attitude; reflecting processes; family life cycle; importance of research and involving the family and networks); 2. Deepening OD practice and self-work; trauma-informed and recovery-based approaches to mental health care (recognising and responding to trauma; working with children; the therapeutic relationship; recovery/empowerment, connectedness and identity; ethics and working with families and networks); 3. Applied OD practice, peer support & integration (power of peers; co-creating peer-supported services; sharing stories and decisions in person-centred care; dialogue and client-driven service development); 4. Holistic approaches to mental health and personal development; reflections and final assessments (emotions, self-regulation and the body; psychosocial, cultural and spiritual aspects of mental illness and recovery; acceptance and compassion in professional practice; the use of self in OD) Methods: Experiential exercises, practice in reflective processes, self-disclosure tasks, family-of-origin activities, roleplay, lectures, yoga and mindfulness; online platform for regular contributions to reflective discussions	1) Enhanced personal development; 2) Enhanced professional development; 3) Training principles that worked well: Mindfulness, value of clinicians/patients perspectives; 4) Training-specific issues: Balancing power within teams, early training uncertainty, insufficient explanations and feedback. 5) Limitations: less directive teaching anxiety provoking and preferred more instruction, need for more experiential or reflective exercises, lack of feedback on the online learning and discussion platform was frustrating
Stewart (2008) Australia	35 (54.3%) Age not reported	Mental health; entry level (Consumer)	No specific training details reported Current (any capacity) Not reported	Not specified	Training needs identified: Advocacy training, communication skills training, administration, policy & legislation, management, counselling/therapy, staff development. Other responses: 1.meeting skills, 2.conflict resolution and aggression management, 3.confidence building, 4. stress management, 5. assertiveness 6. understanding health system and associated jargon. Most support mandatory training.

Toikko (2016) Finland	12 Gender and age not reported	Mental health; entry level (Consumer)	Training consumers as PSWs Future (paid) 1 day fortnightly for 10 months	Content: 1. Personal experiences with mental health ("life line" used as a learning tool); 2. Mental health-produced knowledge from a professional perspective; 3. Expertise focused on examples of existing tasks where service users had been involved as experts by experience in health and social services. Methods: Groups are interactive where members tell and listen to stories, allowing them to compare their experiences, learn from the process, and create generalized experiences.	Themes: 1) Creating distance from experiences; 2) Sharing experiences with peers and friends; 3) Combining experiences with existing competences; 4) Developing an orientation toward the future. The training produced new activities within hospital in which experts by experience have taken part. Participants who had active roles within the hospital extremely satisfied with the training and the tasks they had participated in since training.
Treloar (2012) Australia	18 (61.1% female) Age range: 27-54. Mean age not reported	AOD; entry level (Consumer)	Training consumers as PSWs Future (paid) 11 sessions	Content and Methods: 1. Following video footage of clients injecting drugs, participants were asked to consider how they could engage peers on the theme of hygiene in injecting practice as a means to discuss hepatitis C prevention; 2. Following another video footage that addressed the concept of routine, habit and 'mindlessness' as an influence on injecting practice, participants subsequently developed peer education messages and strategies based on hepatitis C risk related to routine and habit in injecting practice; 3. Participants again reported on their peer education attempt	Participants 1/ identified strategies that could be employed when engaging with their peers; strategies were influenced by macro- (social and legal contexts) and meso level (organizational and funding) forces; 2/ gathered knowledge about safer injecting and the prevention of hepatitis C infection; 3/ acknowledged their own and their peers' experiences including the realities of social and economic marginalization, the impact of hospitalization, drug dependence, and overdose. 4/ This program highlights the need for both flexible programs and supportive funders.
Willging (2016) USA	4 Gender and age not reported	Mental health and AOD; entry level (Consumer)	Training for peer advocates. Future (paid) 4-day training & coaching	Content (in-person training): information on mental health and substance abuse, minority stress, diversity within LGBTQ communities, and rural treatment systems; basic helping skills, effective support for people seeking mental health services; skill development focused on needs assessment, solution-focused helping, suicide prevention, conducting presentations, negotiating communication conflicts, outreach, ethical decision making, and self-care. Content (phone coaching): ongoing mentorship to augment knowledge and skills gained from in-person training; forums for questions, advice seeking, sharing broader concerns	Themes identified: (1) coaching support - Advocates appreciated support from coaches, although, hiring a full-time coordinator and supervisor would strengthen the support and give more immediate access to in-depth consultation. (2) peer advocate skills and preparation – Advocates felt unprepared and unsupported to perform outreach. They needed training in technology and outreach skills. While the basics of establishing support groups and organizing social events were covered, these topics were not explored in sufficient depth due to the truncated timeline. (3) working with help seekers - (positives) Advocates believed their work was significant and valuable for self and others; developed confidence in their new roles; learnt the value of their work and how easily it could slip into case management; offered supportive relationships without judgment; provided optimal support for less-distressed help seekers; (negatives) felt underprepared when working with more severe and complex mental health and substance use issues; experienced delays or challenges in connecting with help seekers; difficulties maintaining consistent contact with help seekers; required support with making effective decisions and protecting their boundaries. (4) Negotiating diversity –Advocates increased familiarity,

		knowledge and confidence with different sexual identities, but needed more help reflecting on stigmatising attitudes, biases, and how to navigate culturally and socio-economically diverse populations. (5) Logistical challenges in rural contexts; (6) Systemic challenges in navigating the mental health system and models of care.

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Appendix 3: Desktop Audit Report

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Our Future - Desktop Audit of Currently Available Trainings

Methods

The desktop audit obtained information about lived and living experience workforce trainings available in Victoria and Australia. The first source of information was the project team, which included some of the most experienced and expert trainers in the lived experience sector. Team members helped identify known providers and other experts to ensure no trainings were undiscovered.

An internet search was also done on terms that included “Consumer OR Carer Training Victoria”, “Consumer OR Carer Workforce Training Victoria”, “Lived Experience Workforce Training Victoria”, “Peer Support Work Training Victoria”, “Consumer OR Carer Consultant Training Victoria” and “Consumer OR Carer Representative Training Victoria”. The first 10 pages of search results were explored for all relevant training.

The available data was constructed in an excel spreadsheet that identified:

- Title, Description, Provider, Location, Cost, Duration, Objectives, Content,
- When the training is running?
- Method of Delivery
- Who designs and delivers the training
- Which workforce/s is it available for?
- What career level is it for?
- Prerequisites, and does it involve assessment?

The spreadsheet tables are included in this appendix.

The training program data was then analysed in light of the project recommendations about development, delivery, content and access. These recommendations were used as quality markers with which to appraise the known training offerings, based on available data. This analysis is tabled in the body of the report as the results of the desktop audit.

Audit findings

How many trainings are available?

There were 56 trainings identified for Victorians. For training available for carers there are 29 trainings available. For consumers there are 42 trainings available. There are currently 5 locations in Victoria offering the only accredited training specifically for the mental health LEW, the Certificate IV in Mental Health Peer Work. A small minority of trainings (7/42) were pitched specifically for the AOD sector.

How are they delivered?

Some of the trainings have changed their delivery format because of COVID-19 so it is unclear exactly how each training will run in the future. However, most offered online training currently as it has been adapted from face-to-face training. Online training has allowed ease of access for shorter trainings and face-to-face has facilitated in more in-depth learning.

National

Face to face	3
Face to face/online	3

Victorian Consumer

Face to face	10
Face to face/online	1
Online	7

Victorian Carer

Face to face	4
Face to face/online	4
Online	9

How long do the trainings go for?

The majority of trainings were less than one day. Some trainings went for longer than one day but less than 5. Very few trainings (2) were training that were longer than 5 days.

Who designed the training?

Almost exclusively, consumer trainings were co-designed or designed by consumers. The same was not the case for the mental health carer trainings as these tended to be designed by organizations representing and made up of carers (Carers Gateway, Carers Victoria) so was not necessarily by carers themselves.

Who delivers the training?

As with who designs the training, consumer training in Victoria is almost exclusively delivered by consumers. Most trainings for mental health carers are delivered by carer organizations although there are exceptions to this.

Who is it available for?

Most of the consumer trainings are available to people who are consumers in general or part of the LEW. This is similar for the carer trainings, which are available to carers or people part of the carer LEW. A number of trainings are available to the whole population as they represent general skills which can also be applied in the LEW

What career level are they for?

These trainings are primarily for people entering the workforce or who have only been in the workforce for a small period of time. There are some exceptions which provide skills for people in

their ‘mid’ career and fewer specifically for leaders. However, many of the these trainings would be useful for people regardless of their length of time or expertise.

Do they involve assessment?

It was unclear whether most of these trainings involved assessment based on the information available. Most did not appear to involve assessment.

What are the entry requirements?

Many of the trainings require people to be currently within the LEW. From the information available there is typically no other barrier to entry except for having the relevant lived experience.

Content of Consumer Training

Content of Carer Training

Training available to LLE workforces in Victoria

	A	B	C	D	E	F	G
1	**Title**	**Description**	**Provider**	**Cost**	**Dates**	**Location**	**Duration**
2	**Delivered in Victoria**						
3	Caring With, Introduction to Carer Peer Work	Entry level training for new family/carer workers in Victoria, delivered in 2016 & 2017	N/A****	Free	Nil	F2F***/Online	2day
4	APSU Leap Training	LEAP prepares participants for peer work in the AOD sector, as well as for further education in AOD related studies. Also an opportunity for people with disrupted education to test the waters	APSU*	Free	Last held 2020	F2F/Online	8 sessions x 4.5 hra
5	LEAP (Lived Experience Applied) Training		APSU	Free	Ongoing	F2F/Online	8 half days/ 3 weeks
6	Working effectively with allies	The workshop explores the role and value of allies, including how to identify allies, intersectional issues and strategies to nurture allyship.	Athena**	Free, funded by CMHL	Ongoing	Online	4 hours
7	History of the consumer movement	This module introduces learners to the history, principles and key concepts from the consumer movement.	Athena	Free, funded by CMHL	In future	Online	<1day
8	What is consumer perspective (the discipline)?	This module explores the discipline of consumer perspective which underpins all consumer workforce roles, including an introduction to basic human rights concepts, examine common	Athena	Free, funded by CMHL	In future	Online	<1day
9	What is the consumer workforce (the roles)?	This module introduces learners to the history, breadth and depth of consumer workforce roles and opportunities.	Athena	Free, funded by CMHL	In future	Online	<1day
10	Making space for difference: Appreciating & engaging diverse views & voices	This module supports learners to contextualise their lived experience critically and reflexively.	Athena	Free, funded by CMHL	In future	Online	<1day
11	Effective consumer perspective advice & consulting (introduction)	It includes an introduction to common advisory situations, engagement and influencing strategies, common traps and practical skills for using your voice with influence	Athena	Free, funded by CMHL	In future	Online	<1day
12	Effective consumer perspective advice & consulting (advanced)	challenging situations. Learners will explore structural barriers & ethical responses, including how to prioritise conflicting issues, critical analysis & questioning.	Athena	Free, funded by CMHL	In future	Online	<1day
13	Working effectively with allies	nurture and draw on allyship in work settings. Learners will look at the concept of allyship in other marginalised communities and consider intersectional issues.	Athena	Free, funded by CMHL	In future	Online	<1day
14	Effective consumer perspective education and training	This module will support consumers working in education and training roles to explore a variety of methods and strategies to iincorporate consumer perspective into learning processes. Learners will	Athena	Free, funded by CMHL	In future	Online	<1day
15	Participatory methods: Coproduction, codesign, engagement & consultation	settings. Learners will explore the participatory ladder, pros & cons & best practice for each level. Particular focus will be given to authentic codesign, co-production & lived-experience led	Athena	Free, funded by CMHL	In future	Online	<1day
16	Carer Skills	The Carer Skills courses provide information, insights & practical tips to help carers develop new understanding & skills important in their caring role. Explore our Carer Skills courses to help	Carer gateway	free	Self-paced	Online	6 X 30-40 mins
17	Employed/Paid Carer Support Group Facilitator Program	Preparing to run a group in your professional capacity	Carers Vic	Free	Ongoing	Online	5 sessions x 2hrs
18	Navigating the Mental Health System	Caring from someone with a mental health illness? Feeling lost and confused about how to access services?	Carers Vic	Free	Ongoing	Online	1hr
19	Communicating with Professionals	Communicating with professionals can be overwhelming and frustrating for carers.	Carers Vic	Free	Ongoing	Online	1hr
20	The Art of Being Assertive	Being assertive helps carers to look after themselves.	Carers Vic	Free	Ongoing	Online	1hr
21	Support Services for Carers	Who supports the carers?	Carers Vic	Free	Ongoing	Online	1hr
22	Strong Boundaries, Strong Carers Workshop in Footscray	When boundaries are crossed	Carers Vic	Free	Ongoing	F2F	2hrs
23	Mental Health First Aid Training For Carers in Footscray	Become a Mental Health First Aider - Complete online modules and workshops	Carers Vic	$88	Ongoing	F2F	6hrs

This table has been compressed to 8 pages. See online version for full table.

	H	I	J	K	L	M	N	O	P	Q
1	**Title**	**Who designed the training?**	**Who delivers the training?**	**Who to? (position, psw etc**	**Career level entry,**	**Assessed**	**How assessed?**	**Objectives of training**	**Topics covered (contents page)**	**Prereq**
2	**Delivered in Victoria**									
3	Caring With, Introduction to Carer Peer Work	Carer	Carer	Carer LEW	entry	no		Carer lived experience workers will be able to connect with their own journey and how to use their lived experience	Who are carers, who are family?, History of consumer, carer and peer support movements,	
4	APSU Leap Training	consumer	consumer	all with aod history	entry/mid	unclear	unclear	Orientation, Advocacy, Ethics, Family Dynamics, First 30 days	AOD Service Sx, Communication, First 30 days, Stages of change	
5	LEAP (Lived Experience Applied) Training	consumer	consumer	AOD Consumers	Entry	No		Assist peer workers to apply best practice peer work in formalised settings	Communication 5. Ethics 6. Family Dynamics 7. First 30 Days 8. Group Work 9. Harm Reduction 10. Mental	AOD consumer
6	Working effectively with allies	Consumers	Consumers	All LEW	Entry	Unclear	unclear	allies, and strategies to nurture and draw on allyship in work settings.		
7	History of the consumer movement	Consumer	Consumers	Consumers	entry	Unclear	unclear			
8	What is consumer perspective (the discipline)?	Consumer	Consumers	Consumers	entry	Unclear	unclear			
9	What is the consumer workforce (the roles)?	Consumer	Consumers	Consumers	entry	Unclear	unclear			
10	Appreciating & engaging diverse views & voices	Consumer	Consumers	Consumers	mid	Unclear	unclear			
11	perspective advice & consulting (introduction)	Consumer	Consumers	Consumers	mid	Unclear	unclear			
12	perspective advice & consulting (advanced)	Consumer	Consumers	Consumers	mid	Unclear	unclear			
13	Working effectively with allies	Consumer	Consumers	Consumers	mid	Unclear	unclear			
14	perspective education and training	Consumer	Consumers	Consumers	mid	Unclear	unclear			
15	Coproduction, codesign, engagement and consultation	Consumer	Consumers	Consumers	mid	Unclear	unclear			
16	Carer Skills	Carer Gateway	Carer Gateway	All Carers	entry	unclear	nil	Develop new understanding and skills important in their caring role		nil
17	Employed/Paid Carer Support Group Facilitator Program	Carers Victoria	Carers Victoria	Carer LEW	entry	unclear	nil	Run and establish peer support work		workforce
18	Navigating the Mental Health System	Carers Vic	Carers Victoria	All Carers	entry	unclear	nil	Navigating the mental health system		nil
19	Communicating with Professionals	Carers Vic	carers Victoria	All Carers	entry	unclear	nil	Communicating with profiessionals		nil
20	The Art of Being Assertive	Carers Vic	Carers Victoria	All Carers	entry	unclear	nil	How to be assertive		nil
21	Support Services for Carers	Carers Vic	Carers Victoria	All Carers	entry	unclear	nil	Support Services available for carers		nil
22	Strong Boundaries, Strong Carers Workshop in Footscray	Carers Vic	Carers Victoria	All Carers	entry	unclear	nil	Boundaries / Self-Care		nil
23	Training For Carers in Footscray	Carers Vic	Carers Victoria	All Carers	entry	unclear	nil	MHFA		nil

Training available to LLE workforces in Victoria

	A	B	C	D	E	F	G
24	**Title**	**Description**	**Provider**	**Cost**	**Dates**	**Location**	**Duration**
25	Caring For Yourself	Do you take better care of the person you are caring for than yourself? If the answer is yes, you will benefit from this workshop.	Carers Vic	Free	Ongoing	Online	1hr
26	Guardianship and Administration	This workshop discusses guardianship & administration orders and the process for making an application to VCAT.	Carers Vic	Free	Ongoing	Online	1hr
27	Powers of Attorney Online Workshop	This workshop discusses powers of attorney & guardianship & administration orders	Carers Vic	Free	Ongoing	Online	1hr
28	introduction To Mental Health - Peer Support	This short course prepares you for entry to accredited training in this field. A sound introduction to the necessary skills & knowledge to establish relationships, clarify needs & work collaboratively	Coonarara house	$40	Last held August	F2F/Online	6 x 90 mins
29	Eating Disorders Victoria	EDV provide peer worker training for their lived experience mentors. It is three-day induction/training program, & professional development activities as required. Also 13 mentoring	Eating Disorders Victoria (EDV)	Free	Ongoing	F2F/Online	Unclear
30	Family Drug Support - Helpline Training	Learn to be a phone line operator	Family Drug Support	$60	Ongoing	F2F/Online	3 days
31	Drug Overdose Peer Education	The primary aim of D.O.P.E is to reduce the incidence of both fatal & non-fatal overdose among current heroin, ATS (amphetamine type substances) & poly drug users in Victoria.	HRVIC	Free	Ongoing	online	1 hour
32	Time for a Change: A dual diagnosis training resource for the Lived Experience Workforce	This workshop has been designed for the Lived Experience Workforce, enabling them to support people they work with who have co-occurring mental health and substance use issues. The topics &	CMHL	Free	Last held July	online	Unclear
33	Consumer Perspective Supervision Training	Training for people wanting to become consumer perspective supervisor	Insideout	Free	Annual	online	12 weeks
34	AOD Intentional Peer Support Core Training	Intentional Peer Support from an AOD lens	IPS/SHARC	unfunded $$$	Ongoing	F2F/Online	5 days
35	Advocacy Skills	This webinar provides an overview of key advocacy tips for people with a lived experience of mental illness or mental health issues, families and carers.	Lived Experience Australia	Free	Self-paced	Online	45 minutes
36	Mental Health First Aid	This course is designed for members of the public, to learn a framework to clarify what support you can realistically provide to others.	MakeShift	220	Ongoing	Online	2 x 2.5hrs
37	Certificate IV in Mental Health	provide a wide range of services, including establishing self-directed recovery relationships and providing recovery oriented mental health services.	Tafe Course	Free	Ongoing	F2F/Online	1 year (FT)
38	Certificate IV in Alcohol and Other Drugs	alcohol and other drug (AOD) abuse problems. You'll learn to provide a range of services, and implement health promotion and community interventions.	Tafe Course	Free	Ongoing	F2F/Online	1 year (FT)
39	Diploma Of Mental Health / Diploma Of Alcohol and Other Drugs	will give you the skills required for you to work within the Mental Health and Alcohol and Other Drugs industry. After successfully completing the course you may choose to find employment as a	Tafe Course	Free	Ongoing	F2F/Online	21 months (FT)
40	Certificate IV in Mental Health Peer Work	Our Certificate IV in Mental Health Peer Work CHC4351 qualification reflects the role of workers who have a lived experience of mental illness as either a consumer or carer. This course will prepare	Tafe Course	Free	Ongoing	F2F/Online	14 months (PT)
41	Foundations in Peer Work	course will introduce you to the fundamentals required to effectively work with an organisation as a peer worker. This course is an essential introduction for any consumers or carers peer workers.	Mental Health Victoria	$895	No scheduled dates	F2F	5 days
42	Professional Practice for Peer Workers: a five day professional development course	For people with a lived experience of mental illness and recovery who are thinking of doing peer support work. The course will introduce all the key skills necessary to do this vital work. Candidates	Mind Australia	1200, $800 (concession)	Ongoing	F2F	Five Days
43	SHARC Peer Mentors in Justice Training	Peer Worker Training for Peer Mentors in Justice Program	SHARC	$990	Ongoing	F2F	5 days
44	SHARC Peer Workforce Training	Peer Worker Training	SHARC	$990	Twice yearly	F2F	5 Days
45	SHARC Support Group Peer Leader Training	Peer Leader Training for Volunteer Peer Leaders of Family Support Groups	SHARC/FDGH	Free	On request	F2F	1/2 day

This table has been compressed to 8 pages. See online version for full table.

	H	I	J	K	L	M	N	O	P	Q
24	**Title**	**Who designed the training?**	**Who delivers the training?**	**(position, psw etc**	**level entry,**	**Assessed**	**How assessed?**	**Objectives of training**	**Topics covered (contents page)**	**Prereq**
25	Caring For Yourself	Carers Vic	carers Victoria	All Carers	entry	unclear	nil	Explore why your health and wellbeing are important, strategies to help better care for yourself.		nil
26	Guardianship and Administration	Carers Vic	carers Victoria	All Carers	entry	unclear	nil	Discuss guardianship and administration orders and the process for making an application to VCAT.		nil
27	Powers of Attorney Online Workshop	Carers Vic	Carers Victoria	All Carers	entry	unclear	nil	Discuss powers of attorney and guardianship and administration orders.		nil
28	introduction To Mental Health - Peer Support	Cert IV trainer	Cert IV Trainer	Everyone	Entry	most likely not		Prepare you for entry to accredited training in this field with a sound introduction to the necessary skills and knowledge to		
29	Eating Disorders Victoria	Unclear	unclear	MH Consumers	Entry	unclear				
30	Family Drug Support - Helpline Training	co-design	co-delivered	AOD Consumers	entry	unclear	nil	Skills to volunteer on the FDS phone line supporting other family members of people with AOD use		AOD
31	Drug Overdose Peer Education	co-design	co-delivered	all people	entry/mid	no				nil
32	diagnosis training resource for the Lived Experience	Co-designed	Co-delivered	All LEW	no					
33	Consumer Perspecive Supervision Training	Co-designed	Consumers	MH Consumers	Mid	yes	mentoring sessions	Prepare someone to be a supervisor		
34	AOD IPS Core Training	Co-designed	Co-delivered	AOD Workforce	Entry			Increase confidence and develop skills in communication and navigating relational parameters		
35	Advocacy Skills	Co-designed	Carer	All LEW	Entry	no		This webinar provides key advocacy tips for people with a lived experience of mental illness or mental health issues, families and carers		nil
36	Mental Health First Aid	Clinicians	Clinicians	Everyone	Entry	unclear	unclear	unclear		
37	Certificate IV in Mental Health Peer Work	Clinicians	Clinicians	Everyone	Entry	Yes	Assessments	Prepare people to enter mental health field	Working with consumers, recovery, wellbeing	
38	Certificate IV in Alcohol and Other Drugs	Clinicians	Clinicians	Everyone	Entry	Yes	Assessments	Prepare people to enter AOD field	morbidity, direct service provision, suicide assesment and intervention	
39	Diploma Of Alcohol and Other Drugs	Clinicians	Clinicians	Everyone	Entry	Yes	Assessments	Prepare people to enter either mental health or AOD field	management, wellbeing, health promotion, recovery	
40	Certificate IV in Mental Health Peer Work	Clinicians/Consumers	Clinicians & Consumers?	MH LEW Workforce	entry	yes	unclear			
41	Foundations in Peer Work	Unclear	Unclear	MH LEW Workforce	Entry	unclear		peer work • Understand the diversity of roles and skills required by a peer		nil
42	Workers: a five day professional development	Unclear	Unclear	MH Consumers	Entry	Unclear			The course covers these areas: Peer support mental health recovery principles, Effective listening, Searching for the	
43	SHARC Peer Mentors in Justice Training	Consumer	Consumer	AOD Consumers	Entry	Unclear		Preparing people to draw on their lived experience, mentor participants, offer empathy, understanding and practical support.		
44	SHARC Peer Workforce Training	Consumer	Consumer	AOD Consumers	Entry/Mid	No	No	Educate peer workers around the concepts and core competencies of the peer work discipline		experience of AOD,
45	SHARC Support Group Peer Leader Training	Consumer	Consumer	AOD Consumers	Nil	No	N/A	Explore key components of the role with a focus on the peer relationship	Peer support mental health recovery principles	experience as a family

	A	B	C	D	E	F	G
46	**Title**	**Description**	**Provider**	**Cost**	**Dates**	**Location**	**Duration**
47	SHARC Helpline Training	Volunteer Helpline Training	SHARC/FDGH	Free	On request	F2F/Online	2 days
48	Single Session Peer Support Work	Applying the Single Session Family Work training for family peer workers	The Bouverie Centre	$190	on request	F2F/Online	1 day
49	Hearing Voices Group Setup and Facilitation Training (Online)	The first two days will cover an in-depth understanding of the Hearing Voices Approach and the second half of the training will cover Voice Profiling & the setup tools & strategies for getting a	Voices Vic	$760	Onging	Online	4 hours x 4 days
50	Hearing Voices Approach Training	Voices Approach, gaining more confidence and tools when working with voice hearers. The second half of the training covers Voice Profiling techniques.	Voices Vic	$485-650	Ongoing	Online	3 days
52		*Association of Participating Service Users, **Athena Consumer Workforce Consulting, ***Face to Face ****Not currently available but included as it shows promise					
53							
54	Delivered in Australia						
55	Roses in the Ocean Peer Workforce Development	is a suite of resources and training for the emerging Suicide Prevention Peer Workforce. It consists of	Roses in the Ocean	1000+	On request	F2F/online	Varies
56	Building a Future Program	Learn to facilitate this program	Wellways	Unclear	Ongoing		4 days
57	My Recovery Program	Learn to facilitate this program	Wellways	Unclear	Ongoing		5 days
58	Duo Program	Learn to facilitate this program	Wellways	Unclear	Ongoing		4 days
59	Wellways to Work Program	Learn to facilitate this program	Wellways	Unclear	Ongoing		5 days
60	eCPR	Emotional CPR (eCPR) is an educational program designed to teach people to assist others through an emotional crisis by three simple steps: C = Connecting, P = emPowering, and R = Revitalizing.	eCPR	Cost varies	Ongoing	F2F/online	12 hours, 3 days
61	Intentional Peer Support	Intentional Peer Support is a way of thinking about and inviting transformative relationships. Practit	IPS + IPS Hub	Gov funded	Ongoing	F2F/online	2 days/5 days
62	ASIST	In ASIST, people learn to apply a suicide intervention model. It helps caregivers recognise when someone may be at risk of suicide. It then explores how to connect with them in ways that	Living Works	< $500	Ongoing	F2F	2 days
63	TACSI codesign training	Trainings into the basics of co-design. the training content varies depending on length of training	TACSI	Quote	On request	F2F	2 days / 5 days
64	SMART Recovery	AOD practitioners, mental health clinicians, peers, professionals and community volunteers everything required to start and run their very own SMART Recovery meeting. . It is available online	SMART Recovery Australia	$390-900	Ongoing	F2F/online	Varies
65							
66	Delivered outside Australia						
67	Lived Experience Transformational Leadership Academy (Let(s)LEAD)	on becoming a transformational leader. There are 10, weekly, 2-hour virtual learning sessions. Each session includes an educational component and experiential learning exercises: group discussions,	Recovery and Community Health	Unknown	Ongoing	Online	6 months
68	Alternatives to Suicide facilitator training	feelings of suicide, as well as what might be worth living for. In “Alt2Su” groups we find strength in coming together to support one another in our times of greatest distress. Our collective wisdom	(previously Western Massachusetts)	$325	Ongoing	In person	3 days
69	Peer Support Accreditation and Certification (Canada)	Mentor Certification based on the Standards of Practice for Mental Health Peer Supporters - AOD and Mental Health	Accreditation and Certification (Canada)	Unknown	Unknown	Canada	Unknown
70	Online Peer Support Worker Training: Becoming an Exploration Facilitator	It is a comprehensive, interactive and practical training of peer support workers and family peer support workers.	Robyn Priest LYT (Live your truth)	CA$750	various	Online	14 days

	H	I	J	K	L	M	N	O	P	Q
46	**Title**	**Who designed the training?**	**Who delivers the training?**	**(position, psw etc**	**level entry,**	**Assessed**	**How assessed?**	**Objectives of training**	**Topics covered (contents page)**	**Prereq**
47	SHARC Helpline Training	Consumer	Consumer	AOD Family Carer	Nil	No	N/A	Develop understandings of ethical practice and workplace legislative requirements	Effective listening	
48	Single Session Peer Support Work	Clinicians	Co-delivered	MH Family Carers	Nil	No			Searching for the flame	
49	and Facilitation Training (Online)	Co-designed	co-delivered	All MH workforce	Mid	Unclear		Identifying 'distinct' voices • Linking the voices to the individual's life history	Moving forward in the journey	Nil
50	Hearing Voices Approach Training	Co-designed	co-delivered	All workforce	All	Unclear		Enhance understanding of the experience of hearing voices & recovery		Nil
52										
53										
54										
55	Roses in the Ocean Peer Workforce Development	Co-designed	Co-delivered	MH LEW Workf	Entry	unclear		Improved understanding of SP Peer Workers, their values, principles and approaches.	Peer Workforce is introduced. Myth-busting: the impact of sigma on SP Peer	
56	Building a Future Program			Consumers	Entry	unclear			participants in developing new ways to improve social and emotional	
57	My Recovery Program			Consumers	Entry	unclear			with a lived experience who are interested in taking steps towards work and/or study.	
58	Duo Program			Dual Dx Carers	Entry	unclear			family, friends and carers in maintaining their own wellness and supporting the recovery of their loved on	
59	Wellways to Work Program			Carers	Entry	unclear			family members, friends and carers who provide support to	
60	eCPR	Consumer	Consumer & C	All people	All	No		world.		
61	Intentional Peer Support	Consumer	Consumer	All LEW	Entry/mi	Yes, Presentation			work to reconnect Explore how we have "come to know what we know"	
62	ASIST	Clinicians	clinicians	all people	entry	unclear		on suicide and interventions; Provide guidance and suicide first-aid to a person at risk in ways that meet their individual safety		
63	TACSI codesign training	Co-designed	clinicians & se	all people	mid	unclear		to be able to do co-design		
64	SMART Recovery	Recovery Australia	Recovery Australia	Services and individuals	Unkno wn	unclear		Prepare volunters and clinicians to facilitate Family Recovery Groups	responses. Challenging unhelpful thinking. Improving communication. Setting healthy boundaries. Developing	
65										
66										
67	Transformational Leadership Academy (Let(s)LEAD)	Co-designed	Co-delivered	Experience Workforce	Mid	Yes	project over a 6-	critical and emerging issues in mental health and other systems of care.	other Week 2 Foundations of Transformational Change and	None
68	Alternatives to Suicide facilitator training	Co-designed	Co-delivered	All interested	entry	no		Teach people in the Alt2Su method so they can run groups		None
69	Peer Support Accreditation and Certification (Canada)	Co-designed	Co-designed	Peer workforce	Entry	No	PSACC Mentor	clear understanding of the Peer Support Accredditation and Certification (Canada) process Standards of Practice and	Competencies for Certification - Hope, Demeanour, Interpersonal Relations, Communication, Self-	
70	Training: Becoming an Exploration Facilitator	Consumer designed	Co-delivered	Peer workforce	entry level	unknown	unknown		• Advocacy	

This table has been compressed to 8 pages. See online version for full table.

Appendix 4: Mental Health Consumer Consultation Report and Content Outline

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Contents

1. Introduction

The mental health consumer workforce can be distinguished from other lived experience workforces in a number of unique ways. Perhaps the most significant difference is that the consumer workforce is founded on a socio-political movement (the consumer/survivor movement) which began in the 1960's and 70's, and influenced this workforce's emphasis on human rights and deliberate distancing from clinical approaches. In Victoria, the consumer workforce is also differentiated by being the first lived experience workforce in the mental health context and thus having a longer history of policy frameworks and, when it began, a stronger foundation in systemic advocacy through the advent of funded consumer consultant roles. One other significant difference between lived experience workforces lies in the contexts within which they are performed. The public mental health sector is differentiated from the Alcohol and Other Drug (AOD) sector because of the constraints of the Mental Health Act and so the consumer workforce has to work within coercive contexts. These matters are briefly discussed below.

The consumer workforce benefits from many decades of knowledge development from the consumer/survivor movement informing its underpinning values, principles and philosophies. For example, the value placed upon human rights and freedoms in this movement can be traced in the resistance to the imposition of power or coercion over others informing consumer workforce practices in both consumer peer support roles and consumer consultancy roles. As well, the consumer workforce regards itself as a discipline, in the same way that social work, nursing and psychology are disciplines. This has been essential in articulating the underpinning theory of our work, describing our practices, workforce needs and experienced barriers (see *Leading the change: co-producing safe, inclusive workplaces for consumer mental health workers*) as well as developing related consumer perspective research and education activity.

The (Victorian) Department of Health and Human Services (DHHS) published its first guide to consumer participation in 1995. The consumer workforce is the earliest of the lived experience (LE) workforces in Victoria with the first four consumer consultants employed in mental health services in 1996. The following year, funding was made available for consumer consultant roles across each of the then 22 Area Mental Health Services. The consumer workforce has therefore had the benefit of policy frameworks to guide its development over a longer period of time than other lived experience workforces.

Mental health services have had a twenty-five year history of working alongside consumer consultants. Consumer consultants take a systems view of change and quality improvement, providing consultancy services to staff and to consumers. While consumer leadership is not yet embedded or sufficiently resourced, exposure of mental health services over time to consumer consultants has enabled instances of cultural change and innovation that might not be seen in the context of more recently established or less resourced lived experience workforces.

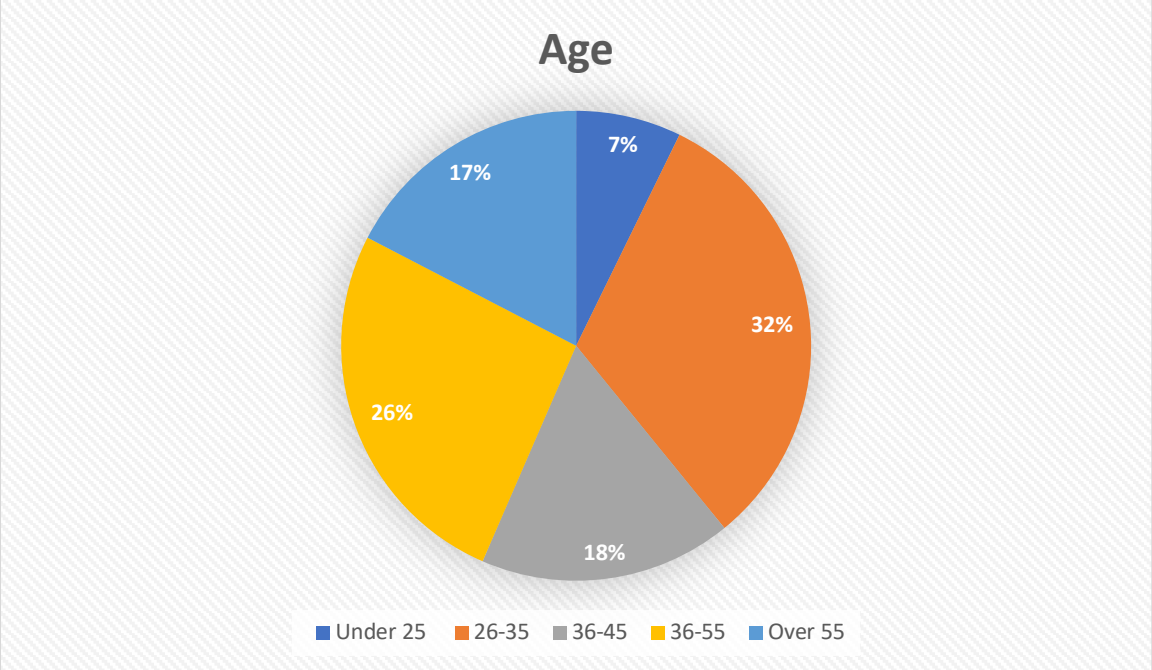
When mental health consumers work in legislated contexts, their practice needs to be human rights informed, distinguishing them from those working in the AOD sector. The principles of mutuality, respecting the world views of others and not having power over others, so integral to the performance of consumer roles, are challenging to uphold in clinical and legislated contexts. Co-option into the established clinical norms and habits of institutions was raised as a concern by participants in our surveys and focus groups. Mental health consumer workforce roles may also,

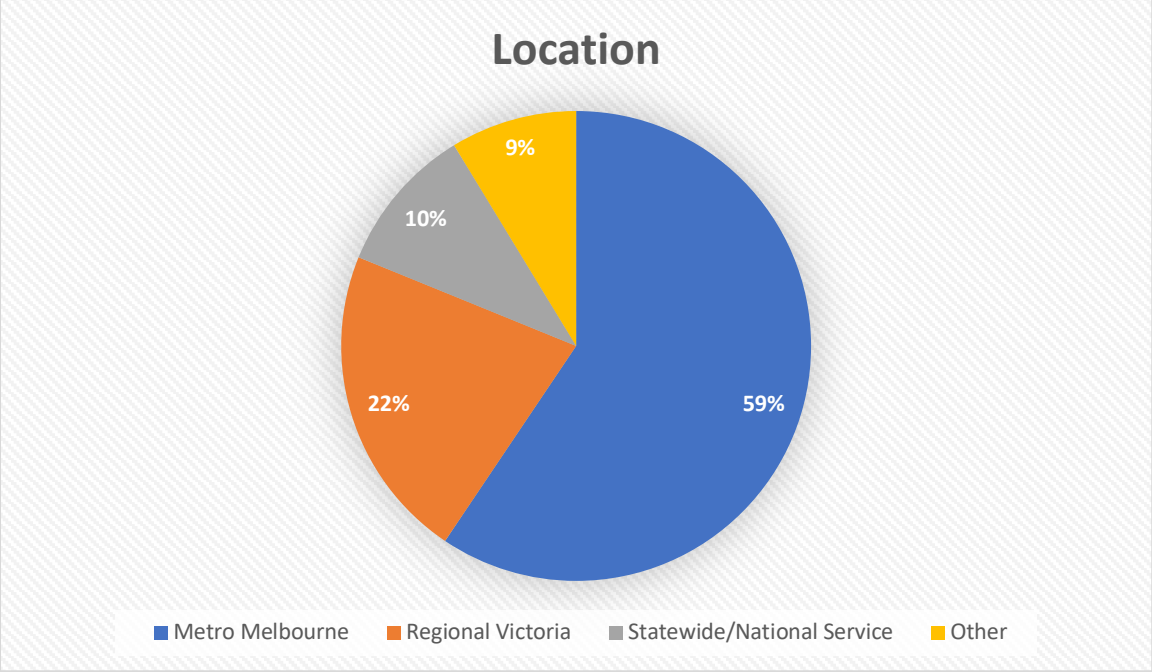
then, be distinguished from other lived experience workforce roles because of the deliberate distancing from, and critique of, the dominance of the clinical worldview, especially if that clinical worldview is put forward at the exclusion of other frameworks.

2. Survey Findings

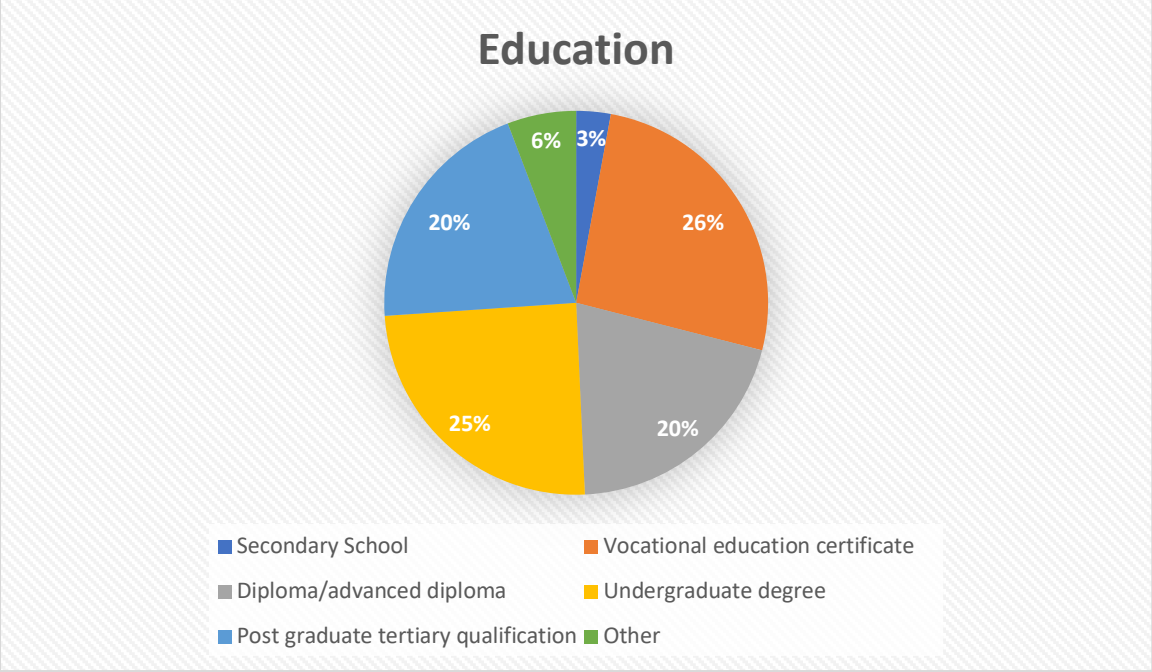
Description of survey sample

The survey respondents had diverse work experiences and came from both clinical and community sectors. They included paid permanent roles as well as a few voluntary positions and more casual work such as being members of advisory groups and committees. The respondents were predominantly peer support workers, which is expected as they now make up the largest group of workers.

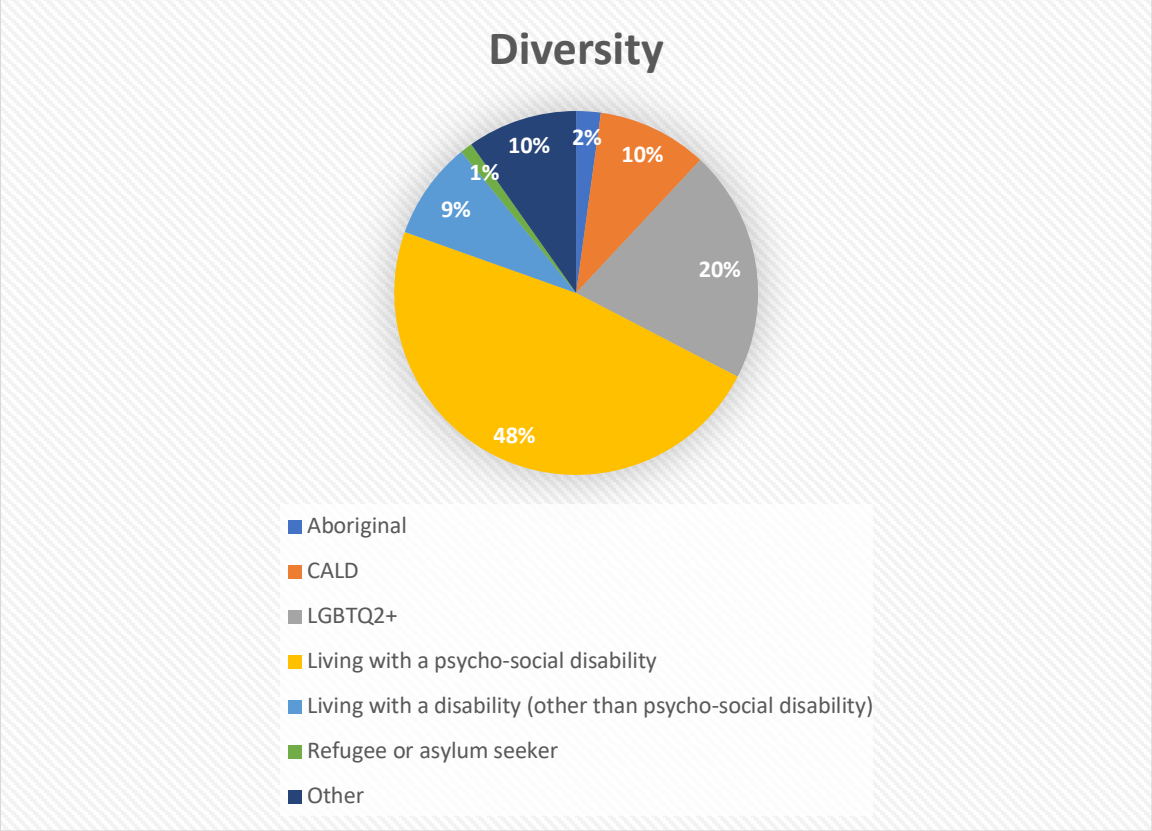




Other responses included roles that were volunteer; online only; and simultaneous metro, regional, and states other than Victoria

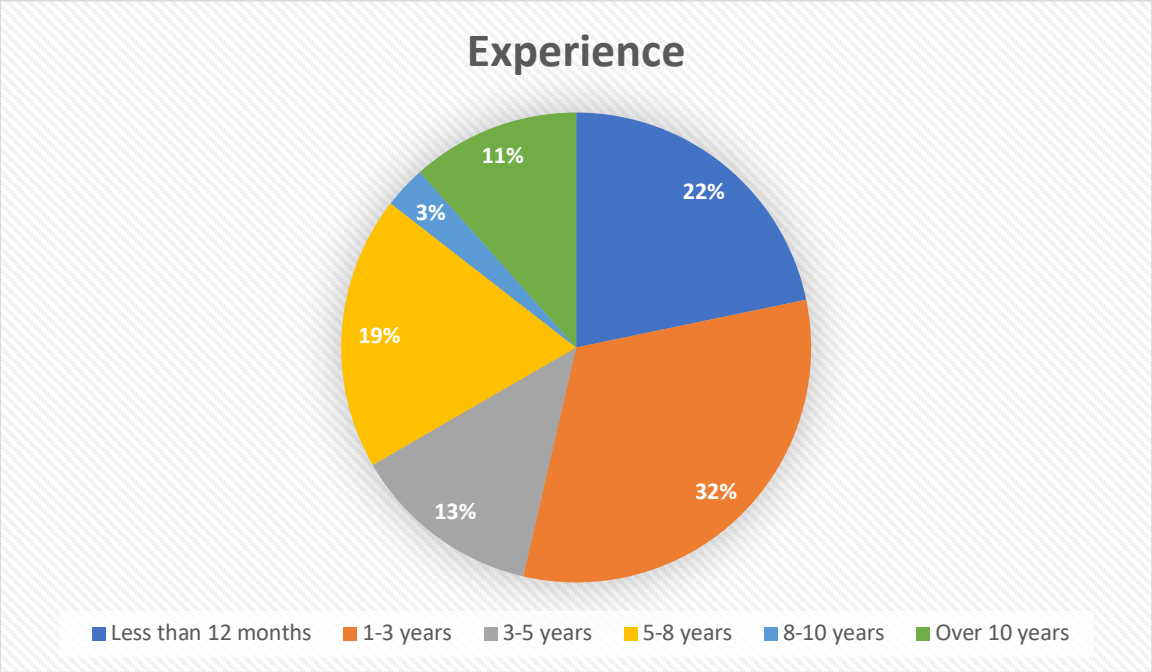


Other responses included school leavers and incomplete tertiary qualifications



No respondents identified as Torres Straight Islander

Other responses included people who don't identify as having a psycho-social disability, but do identify with having a lived experience of mental health matters (currently and/or historically)



What we have now: experience of existing training courses in first 12 months

Survey respondents were asked questions about 19 different existing training courses which, at the time of the survey, were relatively well known in the sector. Questions included:

- Did you complete this course in your first twelve months, or before you started?
- Which of these trainings felt most important or relevant to you?
- Is there any training you wouldn't recommend lived experience workers do?

Training that is recommended and why

It is worth noting at the outset, that this project was formed with the knowledge that existing training is insufficient to meet the needs of the mental health consumer workforce, and responses largely confirmed this assumption with 36% of respondents reporting they received no training in their first twelve months and none of these courses being rated as important or relevant by the majority of respondents.

The highest scoring course was Intentional Peer Support, but only at 38% (see further results in table below).

Views of existing courses	*Completed in first 12 months (n=55)*	*Important or relevant (n=55)*	*Do not recommend (n=46)*
Intentional Peer Support (IPS) (5-day)	31%	38%	9%
Mental Health First Aid (MHFA)	18%	33%	15%
Organisation-run intro to peer work	16%	18%	0%
Facilitating peer groups	15%	20%	7%
ASIST	11%	20%	7%
Cert IV in MH	9%	16%	4%
eCPR	7%	15%	4%
Cert IV in MH peer work	5%	18%	4%
Drug Overdose Peer Ed	4%	4%	2%
SHARC Peer Work	4%	7%	0%
Cert IV in AOD	2%	5%	2%
Dual dip MH & AOD	2%	7%	0%
Foundations of Peer Work (MHV)	2%	7%	0%
No training in first 12 months	36%	n/a	n/a

Respondents could specify 'other' training completed in their first twelve months. Six of nineteen respondents (32%) identified lived-experience specific training including peer work, being a consumer consultant and peer research.

Views on the importance of training completed during workers' first-year was different depending on the type of first job role. For example, IPS was rated as important or relevant by 67% of those

people whose first role was as a consumer peer worker (see table below), but only by 22% of consumer consultants. This is to be expected given that IPS is designed for peer workers, whereas very few training courses are specifically tailored to most other consumer perspective roles.

Mental health consumer roles	*n*	Highest rated courses				
		IPS	*MHFA*	*ASIST*	*Cert IV PW*	*eCPR*
Peer worker	21	67%	33%	19%	19%	24%
Consumer representative	14	14%	29%	14%	29%	7%
Consultant	9	22%	33%	22%	0%	22%
Peer group facilitator	4	25%	0%	0%	0%	0%
Consumer educator	2	0%	50%	0%	0%	0%
Consumer manager	2	0%	50%	0%	0%	0%
Consumer researcher	2	50%	0%	0%	0%	0%
Other	3	33%	33%	67%	67%	33%
Total	***57***	***37%***	***30%***	***18%***	***18%***	***14%***

[yellow cells are the highest scoring course for that job role]

Respondents could explain why they rated a course as they did. Comments were not provided for all courses and some comments were not specific enough to understand which course they referred to. Remaining responses have been analysed as follows:

Intentional Peer Support

Respondent comments were grouped into four themes in support of the Intentional Peer Support course, including:

a) IPS is necessary and directly relevant to peer support work

"IPS has been an INTEGRAL framework in me being able to understand how to be a peer support worker. The core training was fantastic…"

b) Practical skills
c) How to utilise lived experience
d) Defining the purpose of peer work roles

"And a better understanding of what lived experience work can look like in practice"

ASIST suicide prevention

The most common reasons that respondents gave for choosing the ASIST suicide prevention course can be grouped into two themes: (a) it is essential to know how to respond to someone experiencing suicidality, and (b) it is necessary to build practical understanding, skills and confidence in situations involving suicide. One participant noted that ASIST was the only course offered on suicide.

Mental Health First Aid (MHFA)

"At the time (10+years ago) it was the only training available for MH consumers."

Survey comments suggest the primary reason given for choosing MHFA is because it was the only course available for these workers when they started (most respondents in this section had been working for more than 8 years). One person indicated that they needed more than MHFA.

Gaps / peer work bias

One respondent pointed out that *"None of the trainings are appropriate for lived experience advisory group roles."* This comment is relevant to the larger cohort of mental health consumer roles in consulting, advisory and advocacy work, research, education and management where there has been very little dedicated education from a consumer perspective.

Training that is not recommended and why

Of the training that respondents identified as *not recommended*, Mental Health First Aid was rated highest at 15% and was identified by one other person as the 'other' option. Also in the 'other' option, one participant identified an organisational in-house training course (5-day peer work training).

Respondents were asked for reasons why they did not recommend some courses and the following reasons were given:

Mental Health First Aid:

- *"It seems out-dated and more about labels than understanding a consumer's perspective"*
- *"It teaches people to refer people to deficit-focused MH clinical services, which are discriminatory and stigmatising"*
- *"Mental Health First Aid is very dry and not relevant compared to IPS"*
- *"Not really relevant"*

PeerZone:

- *"It is not relevant with the consumers we deal with in our area and has been focused on 1 specific culture"*

SHARC peer work training:

- *"I would not recommend the SHARC peer worker training for mental health peer workers because it feels too clinicalised and does not feel in line with the values of peer support work"*

Intentional Peer Support

- *"I would recommend doing the CRT IV in Mental Health Peer Work prior to doing IPS"*
- *"It was difficult to follow and didn't feel relevant to my role"*

What we need: learning areas and priorities

These two questions went beyond the training that people have actually received, which is recognised as relatively limited, and asked about potential learning topics and areas. The questions included:

1. "This is a list of common content across current entry-level training for lived experience workers in Victoria. Pick up to five that you think are the most important topics for new lived experience workers to understand." (list of pre-defined options)
2. "What topics do you feel are most important to cover in the first 12 months as a new lived experience worker?" (open-ended responses)

Learning area priorities (from pre-defined options)

Learning areas	Priorities by years of experience				Total % *(n=61)*
	<12m *(n=14)*	**1-5y** *(n=25)*	**5-10y** *(n=13)*	**>10y** *(n=9)*	
Using your lived experience (as a consumer)	**79%**	72%	54%	67%	**69%**
Assisting people who are suicidal or in emotional crisis	29%	52%	69%	56%	**51%**
Boundaries	29%	44%	46%	67%	**44%**
How to care for yourself	36%	44%	62%	33%	**44%**
How to advocate for someone or yourself	14%	44%	77%	33%	**43%**
How to communicate with other professionals	36%	44%	46%	33%	**41%**
How to navigate the mental health system	36%	28%	54%	67%	**41%**
How to facilitate groups (for consumers)	29%	44%	23%	11%	**31%**
Discipline of consumer perspective	43%	20%	23%	33%	**28%**
Roles in the lived experience workforces	43%	28%	8%	33%	**28%**
Co-production, co-design	43%	32%	8%	22%	**28%**
History of the Consumer Movement	**50%**	12%	8%	11%	**20%**
Supported, shared & substitute decision making	21%	28%	8%	11%	**20%**
Dual diagnosis – Mental Health and AOD	21%	4%	0%	22%	**10%**
Phone helpline training	0%	12%	15%	0%	**8%**
Drug overdose training	0%	12%	0%	0%	**5%**
Guardianship, power of attorney & other legal decision-making	0%	4%	0%	0%	**2%**
How to work with people in the forensic system	0%	0%	0%	0%	**0%**

** % under years of experience is for that demographic, total column is across the whole of the consumer cohort. Highlighted cells indicate top priorities based on years of experience.*

From the above data, eight learning areas have been prioritised in the table below:

Priority	Learning area	Rating by respondents
A	**1. Using your lived experience**	69% of all consumer respondents ranked this in their top five priority learning areas, however it was 79% for people in their first year of work and gradually tailed off with more experience.
B	**2. Assisting people who are suicidal or in emotional crisis**	51% of all consumer respondents ranked this in their top five priority learning areas. Only 29% of people in their first years of experience ranked this area, but it was above 50% for all other groups and increased with years of experience. This learning area did not emerge in the focus groups.
	3. History of the consumer movement	Additionally, the learning area of history of the consumer movement was identified as the second-highest priority for 50% of consumer workers in their first year of work.

C	**4. How to communicate with other professionals**	41% importance across all years of experience peaking at 46% for respondents with 5-10 years of experience.
	5. How to navigate the mental health and/or AOD system	These learning areas averaged 41% importance but increased in importance for those with more years of experience peaking at ratings over 60%.
	6. How to care for yourself	
	7. How to advocate for someone or yourself	These areas increased in importance for people with more years of experience to over 67% with a noticeable difference between new workers and very experienced workers.
	8. Boundaries	

Learning area priorities (from open-ended responses)

In this question, respondents were asked an open question: *What topics do you feel are most important to cover in the first 12 months as a new lived experience worker?*

Responses to this question were mapped against themes that emerged from focus groups (see below). Most learning areas identified in this question closely matched the focus groups with some new areas emerging as well.

Most important topics in the first 12 months as a new lived experience worker?	No. of responses (n=57)
Consumer perspective discipline foundations *Values, principles, values* *History, foundations & history of consumer perspective work, LE philosophy & history, history of peer support* *Consumer perspective, non-clinical nature of our work* *Define role, understand role, role & responsibilities, function & purpose, clear in roles, scope of practice* *Power imbalances* *Recovery* *Framework for lived experience* *Ethics & boundaries (x2), boundaries and obligations. We note that boundaries exist but are conceptualised quite differently in consumer perspective to clinical practice, and these differences form an important element of discipline foundations. Further clarity on this emerges in focus group results.* *Peer identity, peer drift*	25
Practice skills – general *Using your lived experience* *What bringing lived experience to your role looks like in a practical sense* *Purposeful disclosure* *Sharing your story safely* *Safe sharing* *Consumer perspective* *Sharing your story* *LE philosophy* *Emotional CPR (x2)*	9
Practice skills – peer support work *Peer support* *Trauma (x5)* *Intentional peer support (x8)* *Recovery, harm minimisation*	20

Language and relationship barriers *Connecting, meaningful engagement* *Mutuality, equity, respect, worldviews, not to rescue or fix anyone, allowing people to be in control of their own supports and recovery* *Provide validation and hope* *Psychosis, suicide, dual diagnosis* *Documentation* *Hearing voices approach*	
Practice skills - Crisis / risk / suicide/emergency	7
Practice skills – advisory/consultant/advocacy *Advocating, advocacy for supported decision making* *Self-advocating (x3)* *Dealing with system politics* *Change agency* *NDIS and advocacy* *Co-production*	7
Interpersonal skills *Managing difficult conversations* *How to deal with clients and staff* *Communication skills (x3)* *Connecting, engaging* *Developing relationships*	10
Ongoing professional development *Separating other people's stress from your own and not taking it home with you* *How to stay well while working in a clinical environment where lived experience may not be valued. How to avoid feeling isolated in the clinical space. The importance of external supervision* *Planning your personal continual learning and development toolbox* *Self-care (x4), resilience/compassion fatigue, burnout* *Clear performance development pathways* *Reflective practice, supervision* *Getting the most out of supervision, change agency, self care*	15
Practice /sector context *Sector landscape* *Finding your place in a community organisation* *Working within a multi-disciplinary team* *Reporting line* *Dealing with politics and organisational systems* *To inform the new lived experience worker of all the services out there. It took me years to find out about all the different services available, which I can refer consumers to.* *How the system/services work*	7
Networking/connection *Community networks and supports* *Building community* *How other consumers feel working in this field*	3
Other *Managing change in organisations* *Dual diagnosis* *Motivational interviewing* *Social acceptance and public awareness*	4

Note: respondent comments are included in each section to add depth of understanding to each topic. Where two or more respondents gave an identical or almost identical response, this is indicated as follows 'x2' (with the number indicating the number of similar responses).

Interest in formal qualifications

85% of consumer worker survey respondents reported qualifications higher than secondary school, with 41% of all consumer workers having qualifications at undergraduate level or higher.

Respondents were asked *"are you interested in completing further education in lived experience perspective work? This could be a certificate, or (if it was available) a diploma or degree in lived experience work."* 61% said they were interested.

Interest in tertiary qualifications	Yes	No	Unsure
Percentage total *(n=61)*	61%	13%	26%

Respondents were also asked *"If you answered yes above, what further education are you (or would you) be interested in?"* The results in the table below show interest is concentrated at certificate through to degree level.

Qualification level interest	One or more responses *(n=43)*					No response
	Certificate	Diploma	Degree	Masters	PhD	
Responses	20	26	20	11	6	17

(n=61). Note: people could select multiple options. Of those people who selected a tertiary education option the average number of options selected was 2.

The data indicated that people were mostly interested in the qualification that was a level above what they currently have. For example:

- People with a vocational certificate were most interested in a diploma
- People with a diploma were most interested in an undergraduate degree
- People with a degree were most interested in a masters

There was one exception to this pattern, where those people with post-graduate qualifications were most interested in gaining a vocational certificate. This could indicate a desire for more applied skills in peer work.

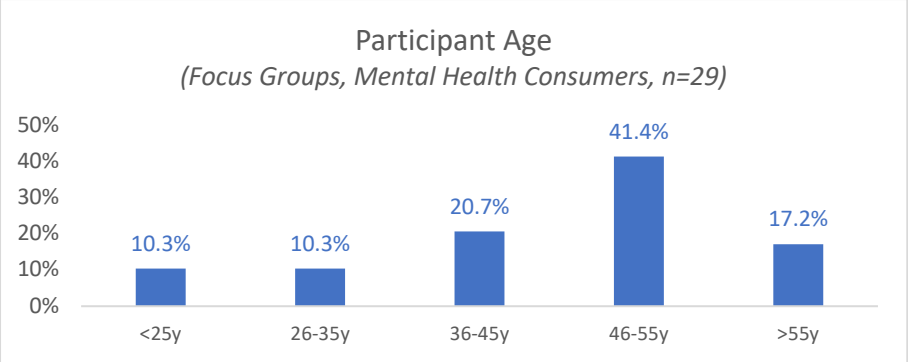
3. Focus Group findings

Description of Focus Group participants

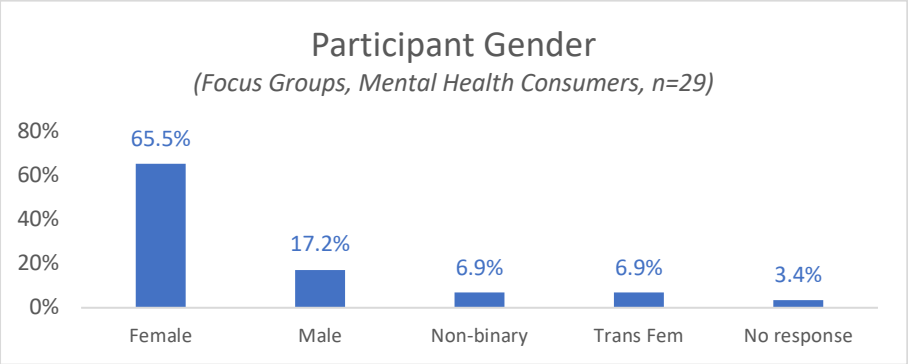
The four focus groups for mental health consumers included 29 people. 72% had worked from a mental health consumer perspective and a further 21% from a dual diagnosis or AOD perspective. One participant worked from a family carer perspective. It should be noted that these focus groups were advertised as being for mental health consumers, however, participants were not asked about their perspective during the groups.

Length of participant experience was spread with 34.5% in their first five years of work, 31% having 5-8 years of experience and 34.5% with 8 or more years of experience. Collectively, participants had experienced all of the different consumer workforce roles.

Participants included all age groups, with 10.3% under 25 years, 10.3% aged 26 – 35 years, 20.7% aged 36 – 45 years and 58.6% aged 46 years or older. It should be noted that this refers to current age and not the age of participants during their first year of consumer work.



Location of participants broadly aligned with the sector distribution, with 69% located in metropolitan Melbourne. 31% of people identified as LGBTIQA+ and 31% identified as being culturally and linguistically diverse. 52% of participants identified as having a psychosocial disability and 17% with other disabilities. In terms of gender, 65.5% identified as female, 17.2% identified as male and 13.8% identified as non-binary or transgender. 3.4% provided no response to the question about gender.



What we have now

Training that is recommended and why

Intentional Peer Support Training (IPS)

IPS was highly valued by many focus group participants for a variety of reasons including providing an underpinning philosophy for consumer work:

> *"IPS was- was fantastic, I thought that was great, especially in terms of the philosophy behind our work, which I think is really super important for people starting out in the role."*

It was also valued for providing a relational framework that was seen as congruent with peer work principles:

> *"…the IPS course was inspirational, and yeah, provided a really relationship-based framework from which to work as a peer…"*

For others, IPS kept them on track with the unique values of consumer work and could provide a defence against being co-opted into clinical values or approaches to work:

"I think for me working in a clinical space, the IPS really gave me a framework to hang things … and also really protected me from- from co-option….I could always, you know, move back to the tasks and principles. So I found that really, really useful."

IPS was also identified as an exemplary way to communicate with other people, especially with consumers, because it was seen as respectful and honouring of the experiences of the other person:

"it's, such a respectful way to communicate with people and such a great way to honour other people's experience…. and I think particularly when you're working with consumers that it's so vital to be able to communicate like that."

IPS was also valued due to the analysis of power that is included in the model and the role of mutual learning as a way to mitigate 'power over' relationships that consumers are often highly sensitized to and seek to avoid:

"…it's a framework that enables you to learn from the person you're there to support…. I just think it's so important to be aware of power, and I think that particular model keeps you maybe more cognizant of that than other models do."

One person revealed that the IPS training was what enabled them to stay in the consumer workforce rather than leaving:

"I don't think I would still be in the consumer workforce if didn't have such intensive access to that sort of training and value space."

Another credited IPS training with the support and guidance that was lacking from their workplace:

"*I lacked support in my workplace but found the guidance I needed through these trainings."*

inside out & associates australia: Consumer Perspective Supervision Training

Although the inside out & associates australia Consumer Perspective Supervision Training was not in scope for this project because it is designed for more experienced consumers learning to become consumer perspective supervisors, it is valuable to note the reasons for participants' high praise for the course. For example, one person described how well this course was able to instil in trainees that consumer perspective is a discipline in its own right:

"…*that was just crucial, like just really starting to just get the sense of it [consumer perspective work] being a discipline."*

Another talked about the value of learning about the consumer movement, to situate current practice within the discipline:

"You know, that consumer perspective supervision, like it wasn't just about, you know, how to go about providing supervision, it was really a journey across the origins of the movement and to where we are today. So it certainly did give us a great background, you know, to why we were there and, you know, what our purpose was."

Human rights training

While we cannot be sure where focus group participants received it, training in working from a human rights perspective was given importance:

"I think that human rights training was, working from a human rights perspective was really key as well."

Training that is not recommended and why

Certificate IV in Mental Health Peer Work

People thought that the Certificate IV in Mental Health Peer Work was lacking or limited:

"It's difficult to hold the philosophy of something like our peers and then also hold the Certificate IV {ideas of] support at the same time. I think there's still a lot of parts in the Certificate that are very bound up with power and, and pull services and doing to people [not] for people. … and I feel tense about them."

This training was also critiqued on grounds that it wasn't always taught by lived experience teachers:

"...[the] *Cert IV for mental health peer work needs to be peer teachers, needs to be Lived Experience teachers. Because I've seen the difference in the teachers and it's huge."*

Mental Health First Aid

Mental Health First Aid was critiqued on grounds of being informed by a clinical approach to responding to human distress as opposed to responding from a peer or consumer perspective approach to human distress:

"...I also agree with what you said earlier on about how useless the Mental Health First Aid course was… I found it not very helpful at all. Too dry and clinical and not very useful."

What we need: learning areas and priorities

There were six main themes emerging from the focus group discussions about what the essential training topics should be for new consumer workers in the first 12 months of their careers. These are: discipline foundations; interpersonal and communication skills; ongoing professional development; specialist knowledge; practice/sector context and leadership. These will be now be further explored and discussed in turn.

Discipline foundations

Topics grouped under this subject include: scope of practice, ethics, discipline principles, consumer movement history and practice skills.

Scope of practice

Training for new consumer workers (and for clinical staff) on understanding the scope of practice, such as *what is and what is not* part of the role was put forward as important. Reasons given included being able to avoid role drift and avoid being co-opted into areas of work that are not part of the consumer role.

> *"I found it very challenging, especially in my first year as a peer support worker, being given a role, being really excited about my new role, and suddenly realizing no one actually understands what I do…I needed to seek support elsewhere, and to not just agree with everything that was being said to me by clinical supervisors."*

Training for organisations and consumer workers about consumer perspective being a discipline in its own right was considered vitally important, including that it is different to carer and clinical perspectives and based on different concepts and values.

> "…[there is an] *inter-changeability that seems to exist between carer lived experience workers and consumer lived experience workers that seems to come from some services. …I would urge that separation of those experiences."*

Similarly, training on the diversity of consumer roles and the settings within which those roles are enacted was put forward as critical for both new consumer workers and organisations.

Ethics of the work

Training in the ethics of the work that is grounded in concepts such as 'nothing about us without us' was seen to be important. This has been a bedrock of the consumer and disability movements expressing the idea that the consumer workforce should be part of all decision-making processes throughout mental health services. It was seen as critical that practices such as duty of care, note taking and boundaries be delineated from clinical forms of these practices. For example, boundaries were discussed as relational in nature rather than 'professional'. This is consistent with Mead's Intentional Peer Support conceptualisation of peer practices as 'relationships grounded in mutuality, where risk and safety are negotiated and both parties set limits about what they each want and need, in the context of learning from and respecting each other' (MacNeil & Mead, 2005[1]; Mead & Copeland, 2000[2]).

In peer support work roles, boundaries were also discussed in relation to another person's trauma, seeking help for yourself, and what to pass on from your conversations with consumers. The point was made that consumer workers also need training in how to maintain boundaries with organisations, for example, not accepting work that is not part of one's job, or in obtaining proper pay for work done.

Discipline principles

The values base of consumer perspective work that participants put forward was generally consistent with Intentional Peer Support values and tasks which is not surprising given that this training has been available to some post-discharge peer workers and is highly valued by consumers.

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[1] MacNeil, C., & Mead, S. (2005). A Narrative Approach to Developing Standards for Trauma-Informed Peer Support. *American Journal of Evaluation*, *26*(2), 231–244.

[2] Mead, S., & Copeland, M. E. (2000). What Recovery Means to Us: Consumers' Perspectives. *Community Mental Health Journal*, *36*(3), p.315.

> *"IPS gave me a framework for my work and gave me a defence against co-option – could always move back to the tasks and principles – quite straightforward, a great way to communicate with people – so respectful, great way to honour others' experience… It was a game changer for me and I still go back to that."*

Training that would assist new workers to understand the challenges of working in the 'big, crazy system' was strongly advocated:

> *"Often in my first year… I'm left in a situation of questioning, am I crazy? Or is this workplace just madness making… I think, often, it's not me, often it is the system… I think it's really important to be able to, somehow articulate that, and to support new consumer workers to know that this work can be really challenging, and it doesn't mean that there's anything wrong with us if we do find it challenging."*

Consumer movement history & understanding human rights

Understanding human rights and training in the history of the consumer movement were also described as key training topics.

Practice skills

A number of topics are captured under the category of 'practice skills' including how to use your personal story to effect, and understanding the potential pitfalls of your story being 'out there' forever. A number of skills related to consumer peer support roles were also identified as important elements of training for people new to the roles, and many of these were also related to IPS principles and tasks such as connection, mutuality and moving forward. Training topics considered vital for consumers in advocacy, consulting and advising roles included how to make change; be strategic; consult with others and initiate or engage in co-design in order to be able to partner with organisations. Additionally, training in welcoming diversity, understanding power and privilege, and engaging with diverse groups (LGBTIQ, cultural awareness, dual diagnosis and others) were considered important.

Interpersonal and/or communication skills

Topics within this subheading include connection, having influence and non-violent communication.

Connection

Important training topics in this category included learning how to enlist supporters; cultivate ally-ship; connect with the broader consumer community and build and sustain relationships. At a practical level, presentation and group facilitation skills were seen as important training areas by participants.

Influence

Learning about having influence was seen as important. This includes key skills to develop early on in people's careers in order to make change in mental health services such as: how to be assertive,

manage conflict, use power and influence and be able to have uncomfortable conversations with clinical colleagues.

> *"In order for things to change, your advocacy skills not only have to be good, but you have to learn to be persistent and understand that that's okay. You are there to challenge people. And that's okay."*

People spoke passionately about the importance of receiving training on how to make change, "joyful activism" and "lobbying" which involved characteristics such as having awareness that change takes time, dealing with the feelings of defeat when change is slow, having each other's back as a consumer workforce and standing true to "our values".

Learning how to pick your battles was also put forward as a skill that was important to learn from the outset:

> *"There are times where you need to, I think, learn to pick your battles. That's what I had to learn in some ways and that's still ongoing 'cause there's some days where I just want to yell and shout… I think that would be really wonderful for new peer support workers to learn. It's definitely something that I've struggled with this year. I'm finding it quite challenging, thinking it was my fault for finding it challenging, wanting to make a lot of change in a system that doesn't really support that change at all."*

Ongoing professional development

Ongoing professional development was seen as important including being able to access training on workplace discrimination, learning how to make the most out of supervision, and receiving training on surviving as a consumer worker working in a clinical space. Consumer worker safety and training on what to do/steps to take/where to go when a worker experiences bullying/discrimination in the workplace was also put forward as important. It was made clear by participants that what was envisaged was not worker 'wellness' plans which were seen as discriminatory practices in themselves unless it was an organisational expectation that all staff would complete one.

Practice/sector context

Important training topics in this grouping included resources and finance, legislative frameworks, and organisational structures/systems.

Training in understanding organisational governance structures; having an understanding of the 'big picture' and understanding how budgets work were considered important training topics for people in their first year of working as a consumer. Consumers working in clinical contexts saw training in legislative frameworks, such as mental health legislation as essential knowledge topics.

Leadership training

Participants expressed that having training in leadership, while it might seem early on in people's careers, would be incredibly significant as Victoria moves quickly with its reforms, with the growth of the consumer workforce and with the range of new consumer roles on the horizon.

> *"I think it's going to be really, really important, you know, expanding the workforce and training people to have people in those leadership roles and they can provide that stuff around oversight, potentially, bigger picture kind of stuff. At the moment, they're still roles that have no teeth. So, you know, you're expected in a sense to do everything that, the other leadership or managers do, but not have that any authority."*

4. Access and barriers to training

Across both the focus groups and the survey, participants readily identified the barriers to training. There are issues of access, organisational limitations and personal limitations. The most significant issue was that of access to training.

While not unexpected, many workers identified as having little to no training early in their work life, it was also clear that individual organisations and services had significantly different approaches to training for the consumer lived experience workforce. Comments made by participants include:

> *"fighting for IPS"*
>
> *"Had to find resources for myself"*
>
> *"organisation not understanding what training is important to my role and my manager thinking I'm attending too much training"*

Related to this, was the issue of cost, both for current training needs and future training goals. A lack of commitment by services, lack of direction in Enterprise Bargaining Agreements (EBAs) specific to lived experience roles and the impact of part-time, casual or contracted (time limited) work all impact on the affordability of additional training outside of organisations. It was also expressed by participants, that having management that was not lived experience impacted on the managers knowing what training was available, suitable and appropriate for a consumer lived experience worker. This created a further barrier to accessing training; workers may have had to look for training when they didn't yet have a good view of what they might need.

Another issue of access was the availability of training during hours that are more accessible for workers, for instance, in the evening if time is not made available during the working day. Also several rural participants commented on training needing to be provided online or regionally for them to be able to participate.

In addition to these access issues, identified barriers to general training were very similar to those related to tertiary study. Issues such as location, availability and personal constraints were common. Understanding the need for reasonable adjustments in relation to training and study was specifically identified in the survey. These are elaborated on in section 5.

Barriers relating to tertiary study were more complex. Importantly, because consumer lived experience workers come into this work with a focus on utilising their lived experience to assist

others, there was some concern expressed about the professionalisation of this workforce. Roennfeldt and Byrne (2021) discuss the motivation for professionalisation as coming from a sector that sees a need for credibility consistent with their own views on what a profession is, as well as greater regulation of the workforce. This can be very problematic for a workforce that fears that professionalisation will necessarily erode the values, principles and uniqueness of consumer designated roles.

> "*It would be awful to mandate compulsory qualifications for lived experience workers, as that would preclude good people out there who have a lot to offer. Qualifications should remain optional, nationwide, for LEWs."*

5. Supports beyond training

What else would have been important to support you in your first 12 months?

The following section combines survey and focus group data. The survey included the following question:

"Our Future is about giving people who are new to Lived Experience roles the best chance to succeed in their job and enjoy a flourishing career. We know this involves training, but what else do you think would have been important to support you in your first 12 months"?

In the survey, there were 57 responses to this question identifying multiple supports which have been categorised into 7 overarching themes: supervision; mentoring and apprenticeship models; LEW team structures; networking with other consumer workers; consumer leadership and career development; role clarity for self and others and ongoing professional development. These themes were also echoed strongly in the focus groups. In addition, focus group participants emphasised the need for connection to the consumer movement, embedding specialist consumer educator roles in mental health services who can train both the consumer workforce and the clinical workforce, having access to debriefing, being able to access a visiting, external consumer leader for consultation, and the need to resource Community Advisory Groups which were seen as being excellent training grounds for people moving into their first paid consumer roles.

Supervision

There were 20 responses from the survey regarding supervision, with many people giving detail about good supervision or emphasising the importance of discipline-specific supervision.

> *"Mental health peer workers should be supervised by mental health supervisors (carer supervise carer and consumer supervise consumer), and that supervision from AOD peer workers to mental health peer workers should not be offered unless it is the preferred option for the PSW. The difference in the way we do peer support has been damaging to some people."*

Being able to access consumer perspective (discipline specific) supervision was seen as essential in supporting consumer workers' practice and critical reflection. Also, training in knowing how to get the most from supervision was seen as an important way to be able to safely discuss ethical practice, receive support and understanding and be challenged. A lot of discussion centred on training that would support consumer workers to be able to analyse the contexts within which they work.

Mentoring and apprenticeship models

15 people spoke about various models of apprenticeships, traineeships or internships that they were aware of in other work areas and suggested strongly that this was a preferred option for early career consumer workers. This was not seen as a total package, with these people also supporting the importance of supervision, networking and team structures. A model of apprenticeship or similar seemed to be of particular interest to regional workers.

> *"Having a buddy for any of 3-6-12 months period to guide and provide backup especially in regional areas when often only worker and up against more outdated ways of managing mental health (sometimes)"*

In the focus groups, people talked about being able to access consumer leaders:

> *"…knowing what, how to access consumer leaders within the movement. And, when it might be good to seek their input on certain things."*

> *"Definitely I think that connection to the movement is, is really important, for me particularly around resilience as well."*

LEW team structures

There were 16 respondents who spoke about not being alone in a role, having senior workers to look to for guidance and examples of lived experience leadership being important.

> *"Connecting with others in lived exp roles particularly management, seeing managers in these roles."*

Networking with other consumer workers

In the survey, 14 people talked about the importance of networking. While many people directly stated that networking with other consumer workers is important, others demonstrated its importance by noting that networking is particularly difficult if you are the only consumer worker in the service. This was emphasised by one person who felt that the LE discipline was not well understood in their service

> *"…like a data base of other lived experience employees to connect with. When I started Consumer Consultant was not a well know discipline in my area."*

LE leadership and career development

The theme of leadership was closely linked with the theme of LEW team structures for the 13 people who talked about it. While formal roles such as management are included in this theme, we have also included other comments that encompass a broader understanding of consumer leadership as having experience and expertise in the field and being supportive peers.

Focus group participants also expressed that having training in leadership, while it might seem early on in people's careers, would be incredibly significant as Victoria moves quickly with its reforms, with the growth of the consumer workforce, and with the range of new consumer roles on the horizon.

> *"How do I then take on the next steps in my career development? Both professionally in terms of skills building… and subsequently hopefully for others. So how do we… not just look at supporting people to get into that workforce, but create opportunities for the organizations in which they work to help them navigate through it? In a way that they have the right to a career in that sort of sense, as any other healthcare professional does as well."*

Role clarity (for self and others)

There were several comments about having a clear job description, however the majority of comments in this theme were in relation to the understanding of LEW by other workers in the organisation, including managers.

> *"Clear position description. A mutual understanding of what your role is and what the organization thinks your role is. A line manager who has sound understanding of LE workforce and is supportive of LE workforce."*

Ongoing professional development

Having access to study leave to take advantage of professional development opportunities was raised as an important support, as was having support for ongoing training.

> *"…it's important for PSWs and Consultants to have ongoing training and reflective opportunities specific to the work that they're doing so they can understand their two distinct roles within a service."*

In the focus groups, the structure of Communities of Practice was raised as a way of addressing ongoing consumer workforce professional development and support. Some participants spoke enthusiastically about the Partnership Dialogues that were held between the DHHS and consumer workforce as a successful form of policy and practical support as well as a networking opportunity and way to access consumer leaders.

Connection to the consumer movement

Focus group participants emphasised having strong and ongoing connection to the consumer movement:

> *"…that connection to the movement is, you know, it's so empowering, and it's such a game changer and it really helps you."*

> *"Definitely I think that connection to the movement is, is really important, for me particularly around resilience as well."*

Exchange visits between consumer leaders

During the focus groups, one participant spoke about the value of having visits from external consumer leaders

> *"…another thing that was really helpful for me as well was having people* [consumer leaders] *come and visit the service that I was working for… I was watching them do their thing, they would also be nurturing you at the same thing and encouraging you to do your thing."*

Organisational training

In the survey, there were many comments referring to training of others, such as organisational readiness and in relation to clinicians' understanding of consumers' roles.

This theme was also raised across all four focus groups. Participants spoke about the exhausting nature of having to educate and re-educate clinicians and others about the nature of consumer perspective work and the range of consumer worker roles.

> *"..nobody seems to be able to understand our language, or our concepts and it's an enormous amount of energy, trying to explain so, it's that, where I guess these roles become so drained by educating other people about what the point of them is. And what's unique about lived experience also, you know, it's just, you know, if there was greater*

clarity around what the roles were and the purpose of them and what's unique about them and then if that can be shared with yeah, kind of, uh, staff more broadly."

"Because it's so incredibly draining and it's [something you have to do] over and over again as well with the massive turnover of staff, it's something that you need to keep doing."

"I agree… having to promote the role externally and internally has been massive in both of my roles that I've had. And that's taken a lot of time and effort, and taken away from one-on-one client work as well."

"I hate the idea of training consumers how to work better within systems without having training to train systems on how to work better with consumers. And I think, where it feels like we're almost training consumer workers to put on an armour and sending them into battle and saying, 'Here, we've equipped you, now go and fight this fight on your own…' But we're not lacking the base level skills and understanding of our role. It's our organizations that are questioning what we're doing constantly to the point that we start questioning what we're doing ourselves... And I think that, yeah, I am sick of training consumer workers and not having the organization understanding what they're being trained in."

One solution was to fund educator roles across mental health services that would engage in this work:

"*Let's just have consumer educators that go to every service and do that"*

Reasonable adjustments

There were also comments in both the survey and focus groups regarding the availability of reasonable adjustments in the context of accessing training and having supports in the performance of roles.

There was one comment in the survey about having a dedicated *consumer workforce* organisation.

"*A dedicated peak body or union that can respond to the unique pitfalls that occur, particularly in the clinical sector (VMIAC has limited time, IMHA is out of scope, MHCC can't take on cases/give an answer on if they will take on cases quickly enough, and HACSU don't understand or support LE work)"*

6. Discussion

What we have now (existing training)

Valued Training

While a key message from the survey data was that no existing training was particularly valuable to the consumer workforce as a whole, both survey and focus groups results did show that Intentional Peer Support (IPS) was highly valued, described as "inspirational", "necessary", "a game changer" and "integral". It was especially valued by those in peer support roles, although, despite this, only 31% of workers had completed IPS training within their first 12 months. IPS training was seen as founded on, and promoting of, consumer values, principles and philosophy. For this reason it was

seen as providing a good foundation for people starting out in the consumer workforce regardless of role. The consumer experts on the partnership group of this project concur strongly with this view.

More specifically, IPS was credited with providing practical skills on how to use lived experience, helping to define the purpose of consumer worker roles, providing a relational framework in working with people, helping to understand others' world views, providing a solid set of tasks and principles to return to, helping protect consumer workers from co-option into clinical approaches to their work, providing a respectful way to communicate with others, attending to how power operates in relationships and as a framework for providing guidance and support, particularly when that is lacking from the organisation. The consumer experts on the partnership group of this project highly recommend that IPS training be made available to all members of the consumer workforce – regardless of role – and therefore it is an expectation that it be provided.

Courses inconsistent with the consumer perspective discipline

Two existing courses were identified as important by some survey respondents and some focus group respondents, however, these courses are inconsistent with the consumer perspective discipline: ASIST suicide prevention and Mental Health First Aid. These results are considered below.

Training on responding to suicide and crisis

ASIST is not appropriate

It is clear from the survey and focus groups that consumer workers require confidence and practical skills and knowledge about what to do when someone is experiencing suicidality. As the only commonly available course on suicide, it's understandable some people rated the ASIST course as a high priority, even though it's inconsistent with peer work values and consumer perspective. Recommended consumer workforce training should include an element of this topic as an alternative to ASIST, grounding practice in consumer perspective principles and values.

Existing training which could be drawn upon in this area include Alternatives to Suicide (The Wildflower Alliance, US). Training in this approach is highly consistent with the consumer perspective and is now available in WA and NSW, or direct via the US. Alternatives to Suicide training, often called 'Alt2Su', differs from ASIST in that it does not direct people into clinical/medical treatment or pathologise distress. It is not about suicide prevention and is entirely non-coercive:

> *"The goal is not to simply force someone to stay alive from moment to moment. Rather, it is to support them to create meaning and a life that they want to live. Not killing one's self is simply a side-effect of all that." (Wildflower Alliance, n.d.)*

This approach allows trust to be built in a peer-to-peer relationship without fear of unwanted coercion or compulsion.

Sourcing alternatives to suicide training:

- Discharged (An Alternatives to Suicide Approach) - WA: Offer short courses on working with people experiencing suicidality: https://www.discharged.org.au/alternatives-to-suicide)
- WA Alliance: Advancing suicide peer support – WA: Offer training for facilitators and resources: https://connectgroups.org.au/alternatives-to-suicide/
- Alternatives to suicide (Alt2Su) - NSW: Training for peer workers on facilitating suicide groups (must have LE of suicidal distress or suicide attempts) https://alt2su-nsw.net/training/

Mental Health First Aid (MHFA) is not appropriate

As with ASIST, MHFA is inconsistent with the consumer perspective discipline because it is based on a pathologising clinical framework. It is not targeted to peer workers, but rather the general public, and the content has been reported to encourage coercive responses by learners (Davidow, S., 2016). This course has received strong criticism by consumer leaders internationally:

> *"First, it is yet another approach that is largely absent any input from people who actually have psychiatric histories themselves. In fact, so many people with first hand experience with deep emotional and/or mental distress were upset about Mental Health First Aid that they have invested a great deal of time in creating alternatives to it."*
>
> *(The Wildflower Alliance, 2018)*

While some respondents rated it as important, these were workers with more experience who said it was the only training available at the time. It is strongly not recommended.

Emotional CPR (sometime referred to as eCPR) was developed by people with lived experience as a direct response to issues in MHFA, and can be considered as a more appropriate alternative to this course. *(Emotional CPR website).*

The consumer experts on the partnership group of this project recommend the purchasing of Emotional CPR and Alternatives to Suicide training to provide the consumer workforce with skills and knowledge that will enable them to work confidently with people experiencing suicidality and distress in ways that are congruent with consumer perspective values and philosophy.

Certificate IV in Mental Health Peer Work

Many respondents who had completed the Certificate IV in Mental Health Peer Work critiqued it on grounds that it had not been well informed by consumer perspective in its design, had an organisational/service focus, and did not focus on power. It was also critiqued on grounds that it was not always delivered or co-delivered by consumers. The course does not map clearly to the identified learning needs of consumer workforce roles. The consumer partnership members recommend that before this qualification can be included as recommended, it needs to be reviewed and updated from a consumer perspective.

What we need (learning areas)

An overriding theme from the focus groups and survey was that consumer workers in their first year are not able to access as much training as they require, and this issue is even more pressing for people in roles other than peer work, such as consumer advisors, consultants, educators and advocates. 33% of consumer worker respondents reported they had received no training at all during or just prior to their first year of work.

Identified priority learning needs were aligned between the survey and focus groups, with only one additional learning need emerging from the survey which was not raised in focus groups - working with people who are experiencing suicide or emotional crisis.

In most cases, the identified learning needs are not matched by existing training courses accessible

to the consumer workforce. However, some existing training from Australia and overseas has been identified which may be purchased to address workforce needs (see recommendations below). Identified learning needs include some areas which are applicable to all consumer perspective workers regardless of role (ie, using your lived experience), while some other needs are specific to role type (ie, peer support worker or consultant).

> *"I think it's the specifics of the topics where, you know, what would a consultancy role, or an advisory role need that is different to you know, a peer support worker role"*

Key learning areas identified consistently across the survey and focus groups are described below.

Part of supporting the consumer workforce in this area also involves identifying training which may deliver messages which are contrary to consumer perspective scope of practice.

Consumer perspective foundations

These needs include consumer perspective discipline foundations, with key topics being: scope of practice, ethics, discipline principles, consumer movement history and practice skills. These foundational learnings are relevant to all consumer workers, regardless of role, and are important to ensure practice integrity.

Scope of practice training focuses on consumer perspective as a distinct discipline, how it is distinct from carer and clinical roles and based in different concepts, values and practices. For example, consumer perspective work recognises and values differing worldviews about experiences which may be seen as 'mental illness' and may support people to make meaning from their experiences in ways which sit outside traditional medicalised/disease discourses. Further, there are particular tasks, concepts and approaches to work from other disciplines that are contrary to consumer perspective values. Training is an important strategy to support new workers to have clarity about their scope of practice in this regard. Ethics of consumer perspective work was identified as a critical learning area given the discipline's foundations in a human rights movement (Chamberlin, 1990) and where, for example, it is unethical to engage in, or promote, compulsory or coercive practice of any kind which brings a different lens to concepts like duty of care. This learning area would include a focus on how boundaries or note taking are conceptualised differently to other mental health disciplines and are much more relational, flexible and co-created practices.

The history of the consumer movement was a high priority learning topic, particularly for people in their first year of work. The roots of consumer worker roles in the consumer movement helps to inform why practice has evolved as it has, and the importance of key practice principles such as mutuality and non-coercive practice. This learning area is underpinned by learning in human rights.

Practice skills

Respondents in surveys and focus groups identified specific learning needs for different roles, as well as more universal skills:

Universal practice skills:

a. Using your lived experience

Specific practice skills

b. Peer support skills
c. Advisory, consultant and advocacy skills: how to make change, be strategic, consult with others and co-design

Communication and interpersonal skills

These skills were a high priority for respondents and included:

Connecting:
Cultivating ally-ship, networking with consumer community, sustaining relationships

Influence:
Assertiveness, conflict, using power and influence and having uncomfortable conversations and non-violent communication.

Respondents identified that these skills need to be underpinned by the principles of consumer perspective work and a commitment to human rights and influencing change while understanding about engaging in change which is long-term in nature.

Respondents articulated clearly that the best training will not be sufficient unless issues of access and other recommendations are also addressed (see below).

7. Training Recommendations

> *"I think it would be fantastic if in years to come, the workforce can keep developing to a point that there are actually kind of pathways in place. So, when you are entering the workforce, you are set up with a mentor, you do have supervision without having to pay for it… I just think it would be really beneficial to have a bit more of a structural pathway to follow, almost like a graduate year… I know there's probably a long way to go before we get to that. But I think that's it."*

The framework outlined below, has been arrived at through the considerable effort of participants and respondents to this project. Resourcing will be needed to properly fund the development or purchase of training. In addition to discussing and outlining the training that is required, participants also identified three principles that future development in this area needs to be based on.

Consumer led training

There was a very strong message from survey respondents and focus group participants that highlighted the need for the development and delivery training to be consumer led, and that this cannot be undertaken as a "one size fits all" approach with other disciplines.

> *"I think consumer workers do need to … really stand true to our values, and to not change them based on the people around us. But that's challenging."*

Although some consumer workers were satisfied to have received any training – regardless of quality or suitability – these reflections came paired with the caveat of needing to determine what was useful for their work and being sure to discard the rest.

Overwhelmingly, there were very strong messages from the workforce that training development and delivery needs to be supported by the consumer idiom "nothing about us, without us, is for us."

> *"We need to get hold of those* [consumer created/delivered/led trainings] *so that we're not co-opted into the clinical bandwidth. Sometimes* [training based in clinical work] *is the only available training that we have and it ... doesn't really gel with our discipline."*

Consumer perspective as a distinct discipline

Training must be specific and tailored the to the consumer workforce and all underpinning consumer principles.

The consumer movement has as diverse and rich a history and theory behind it as any other mental health profession – including other lived and living experience disciplines – and should be treated as such. If psychiatrists wouldn't attend specialist training designed for psychologists, why would that differ in non-clinical roles?

> *"I feel very often we become token voices or just another tick box for the group to go 'yep, they've attended as well.' That's a horrible feeling."*

The consumer discipline is a specialist field with well-established (and evolving) resources and literature. However, there is consistent misunderstanding of what consumer work is, often resulting in pressure from clinical or executive colleagues and/or managers to perform tasks that serve organisational needs rather than that of consumers'.

> "*Because they don't understand that we are a discipline and I think that's really important for them. And I think once it starts to kick in, that message starts to kick in, this is a discipline... we don't have to explain, 'I'm a peer worker on the IPU; I'm a peer worker in community or PARC' … they've got to understand our discipline*"

Systemic support

It was noted in the focus groups that merely training the consumer workforces was insufficient to address the lack of understanding, acceptance, or belief in lived and living experience perspectives. A pervasive lack of "buy-in" from services plays an inseparable part in stifling both the work and workers from being fully realised and integrated into their workplace.

> *"Unfortunately, we're still in a state where there are a lot of clinicians overseeing our workforce. And I think it should be compulsory for anyone who is overseeing the workforce to also attend the training that we attend, to know all of the same things that we're being taught, even if they don't understand it from the basis of their own lived experience."*

The lack of mandatory professional development for clinical staff on consumer work results in consumer workers needing to "thread the needle" of doing what their discipline demands, pushing back on organisational expectations, all while managing their own wellbeing (alongside the

wellbeing of co-workers). These require complicated communication skills where consumer workers are required to educate their workplace from a place of little to no influence, severe power imbalances and little reciprocation of this effort and energy from services' side.

> *"Because it's so incredibly draining and it's* [something you have to do] *over and over again as well with the massive turnover of staff, it's something that you need to keep doing."*

This unacknowledged, often unconsciously habitual, professional coercion carries with it significant risk of peer drift alongside common occurrences of disciplinary action against consumer employees and workplace discrimination.

Organisational structures need to be created and upheld to support and champion consumer work and philosophy as an evidenced, effective, and valued part of the mental health sector. This necessitates a significant culture shift from clinical disciplines – particularly executive and managerial staff – to ally with and prioritise consumer work if any meaningful systemic change is to occur.

> **"***I'm trying to say, if I'm articulating this the way I'd like, is that's* [organisational co-option] *somehow an opportunity for us to acknowledge when a discomfort or a challenge – whatever we call it – comes up, and be able to see that as an opportunity to advocate, to create a conversation for some change, right? It's not just 'cause there's something wrong with us. In fact, most of the time, it isn't, it's 'cause there's something wrong with the fricking system. So how do we have the strength within ourselves to be able to see that, do what we need to in the moment, be able to come back and create a conversation that actually helps to deliberate some change.***"**

Training framework recommendation: Mental health consumer workforce

This framework should be read in the context of findings and discussion above which provides greater detail and context.

Part 1: Consumer perspective discipline foundations

Scope of practice

- What's in & what's out of consumer roles
- Avoiding co-option/drift
- Consumer perspective as a discipline in its own right
- Difference to carer and clinician roles – concepts, values
- Diversity of our roles & settings

Ethics

- Respecting consumer boundaries/consent to share
- Duty of care from a consumer perspective
- Nothing about us without us

Discipline principles

- Values base
- Knowing our perspective, recognising tokenism

- Recognising structural/organisational issues – new workers need to understand the scale of the challenge - 'big, crazy system'
- Vulnerability of our work

Understanding human rights

- History & context
- Class, cultural, disability, feminist, intersectionality, LGBTIQ+

Consumer movement history

- Activism
- Workforce

Part 2: Applied practice skills

Use of personal story

- When & how; what & who for?
- Intention & influence

Peer support roles

- Note writing from consumer perspective
- IPS tasks especially connection
- Trauma
- Working with people experiencing suicide and crisis from consumer perspective (Alternatives to Suicide)

Consultant, advisory, advocacy roles

- How to make change, advocate
- Big picture in advocacy (strategy?)
- Codesign & coproduction

Welcoming Diversity

- Diversity, power & privilege
- Engaging with diverse groups (LGBTIQ+, cultural awareness, dual diagnosis, dual disability etc.)

Part 3: Interpersonal & communication skills

Connection

- Relationships & networking: with the broader consumer community; relational training; enlisting supporters
- Allyship
- Group facilitation skills
- Presentation skills
- Co-reflection

Influence

- Assertiveness: standing up for ourselves, for consumer perspective (especially in clinical settings), getting space in meetings
- Managing conflict
- Power & influence: how to use the power we have, how to have uncomfortable conversations with clinical colleagues

Non-violent communication

Part 4: Ongoing professional development

Discrimination & workplace safety

- What to do
- Discriminatory wellness plans
- Power

Supervision

- Getting the most out of it
- Importance of discipline specific supervision

Not-wellbeing/surviving in these spaces

- Debriefing
- Dealing with difficult dynamics
- Working with allies, colleagues, and tolerators

Part 5: Practice/sector context

Resources, finance

- Executive & governance structures
- Budgets & funding

Legislative frameworks

- Budgets & funding
- The (new) mental health act
- NDIS legislation
- Workplace rights & industrial protections
- Tribunal hearings

Organisational structures/systems

- Understanding the MH system
- Internal processes
- Organisational readiness & resistance
- Working within the system
- Providing feedback

Part 6: Leadership

Career pathways & leadership

- Mentorship
- Championing consumer perspective
- Chairing meetings

Career progression

What needs to be developed and what can be purchased

Training framework element	Topics	Existing (purchase)	To be developed	Development / sourcing needs
Consumer perspective discipline foundations	Scope of practice	X		Athena CWC
	Ethics		X	Specific to CP
	Discipline principles		X	Athena CWC
	Consumer movement history	X		Athena CWC
	Understanding Human Rights		X	Specific to CP
Applied practice skills	Use of personal story		X	
	Diversity, power and privilege		X	Athena CWC
	Engaging with diverse groups		X	
	Peer support roles			
	Note writing from CP		X	
	IPS	X		IPS
	Trauma		X	Indigo Daya
	Working with people experiencing suicide & crisis from CP			Alternatives to Suicide (via NSW, WA or the US)
	Consultant, advisory, advocacy roles			
	How to make change, advocate	X		Athena CWC or Roper & Bennetts
	Big picture in advocacy		X	Athena CWC
	Strategic thinking		X	Specific to CP
	Coproduction & codesign	X		TACSI or Athena CWC
Interpersonal & communication skills	Non-violent communication	X		
	Connection			
	Relationships & networking		X	
	Allyship	X		Athena CWC
	Group facilitation skills		X	Specific to CP
	Presentation skills	X		
	Influence			
	Assertiveness training		X	Specific to CP
	Managing conflict		X	Specific to CP
	Power & influence		X	Athena CWC
Ongoing professional development	Discrimination & workplace safety		X	Specific to CP
	Supervision	X		inside out & associates australia

	Surviving in these spaces		X	
Practice/sector context	Resources, finance	X		
	Legislative frameworks		X	
	Organisational structures and systems		X	
Leadership	Career pathways & leadership		X	Athena CWC
	Career progression		X	

8. Recommendations

What follows is a summary of what consumers in the focus groups and surveys told us about how training alone would not address consumer workforce needs. Respondents told us that organisations themselves needed training in how to maximise the effectiveness of consumer workforce roles and to invest in the structures that would support early career consumer workers.

- Consumers recommended **organisations need to be trained up** as training the consumer workforce in isolation will only go so far. Designated areas included:
    - for organisations to be trained in consumer perspective work; the variety of consumer roles and their scope;
    - ways that staff and management should be resourcing the consumer work agenda;
    - how to avoid being tokenistic;
    - ways that consumer workforce practices are different from clinical practices (e.g. note taking);
    - providing safe work conditions for the consumer workforce e.g. anti-discrimination practices, understanding of and provision of reasonable accommodations for the consumer workforce
- Organisations need to **encourage, resource and fund** the professional development of the consumer workforce. This may mean backfilling consumer roles and ensuring there is dedicated time for professional development activity.
- Very strong feedback that **training is not enough**. Structural requirements include lived experience team structures, such as:
    - being able to work in a team of consumer workers;
    - a number of senior consumer workers in a service;
    - consumers in management and executive roles
- Consumer workers need opportunities **as part of their roles**, to connect and network with the consumer movement, and with the broader consumer workforce.
- The government should resume provision/facilitation of 'partnership dialogues' where consumer workforce meets directly with government decision makers
- **In addition to training**, access to discipline specific supervision, co-reflection and mentoring of consumer workers is essential to prepare people for their roles. Systemic supports include: opportunities for regular debriefing, having access to visits/expertise from independent external consumer leaders to consult with.
- Investing in CAGs is a vital component in upskilling future consumer workforce - this is where many consumers have their first experiences of involvement in consumer work.
- Training needs to be customised, it cannot be one size fits all, both within training across different consumer roles as well as across the LEW workforce
- Specialist senior consumer educator roles who can support the consumer workforce and the clinical workforce are important to embed consumer perspective in organisations

- Apprenticeships, line management, supportive performance development opportunities are needed **to support early career pathways**.
- **Genuine opportunities** for career development, leadership opportunities and articulation into existing educational pathways are needed, especially as the LEW rapidly grows. Partnerships with Universities and TAFES to achieve this goal should be explored.

Appendix 5: AOD Consumer Consultation Report and Content Outline

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Self Help Addiction Resource Centre

Our Future
AOD Consumer Perspective

Findings from Consumer Focus Groups and Surveys

CONTENTS

1 Introduction

The Alcohol and Other Drug (AOD) lived/living experience (LLE) workforce has been active in AOD in Victoria since the 1980s e.g. The Understanding and Support (US) Society was established in 1986 by peers wishing to support people seeking recovery from substance dependence. It started to grow as a professional discipline in 2014 and the LLE workforce is now recognised as an integral part of quality service delivery. Having been an established discipline in Mental Health (MH), it is now firmly established and has grown significantly within AOD with over 50 AOD peer workers (both lived and living experience) employed in agencies in Victoria.

As masters of lived/living experience, peer workers work within, and alongside, multidisciplinary teams in a number of AOD settings. A unique discipline, it faces many challenges in traditional service settings and, as an emerging workforce, the AOD LLE workforce leverages off the learnings of allied sectors.

Peer work is a well-established and proven treatment modality in the allied sectors and a valuable adjunct to existing services in the AOD sector. As it continues to expand, efficacy relies on cross-sectorial collaboration, leveraging off the successes of the LLE experience workforce already established and mutually learning from previous enquiry.

An effective approach in enriching drug treatment and expanding recovery outcomes, there is sector-wide enthusiasm for LLE experience work and an unprecedented demand for LLE workers. The Victorian Department of Health's (DHHS) investment in the expansion of LLE workers in AOD services has helped to ensure the sector can effectively implement, support and grow the AOD Peer Workforce. In Victoria, the last 5 years have seen the development of AOD Peer Worker training for LLE workers; Organisational Readiness Training for agencies implementing, sustaining or growing a LLE workforce; a Peer Worker Supervision framework; an AOD Peer Workforce Community of Practice; and numerous peer worker positions in the sector.

This report has been compiled by Brendan Ritchie, Peer Projects Development Officer; Amelia Berg, APSU Project Worker and Matthew Corbett, Manager – Lived Experience Workforce and Advocacy.

2 Survey Findings

2.1 Survey Samples

55 people participated in the survey in the AOD Consumer and Dual Diagnosis cohort. They represented paid and volunteer LLE roles across a range of agencies and were primarily peer workers.

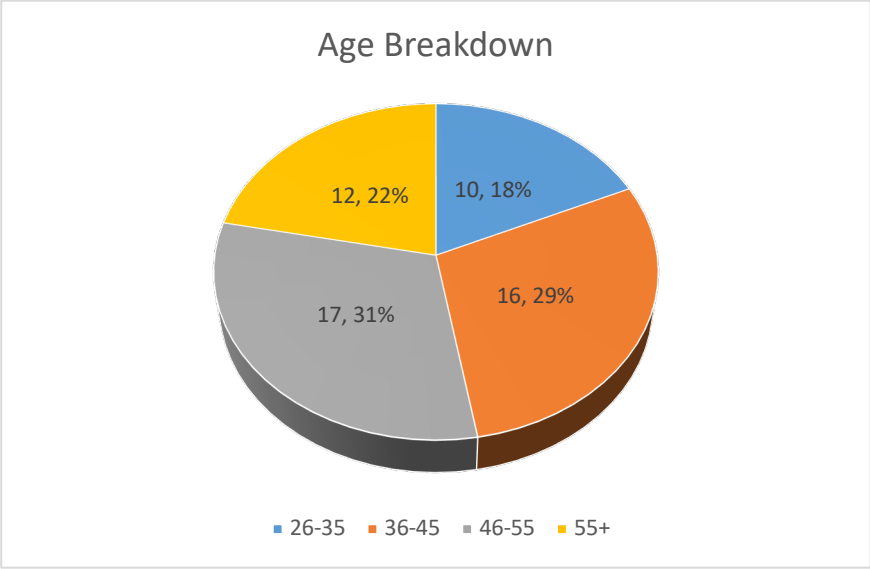
2.2 Limitations

The reliability of the survey data is dependent on the following factors:

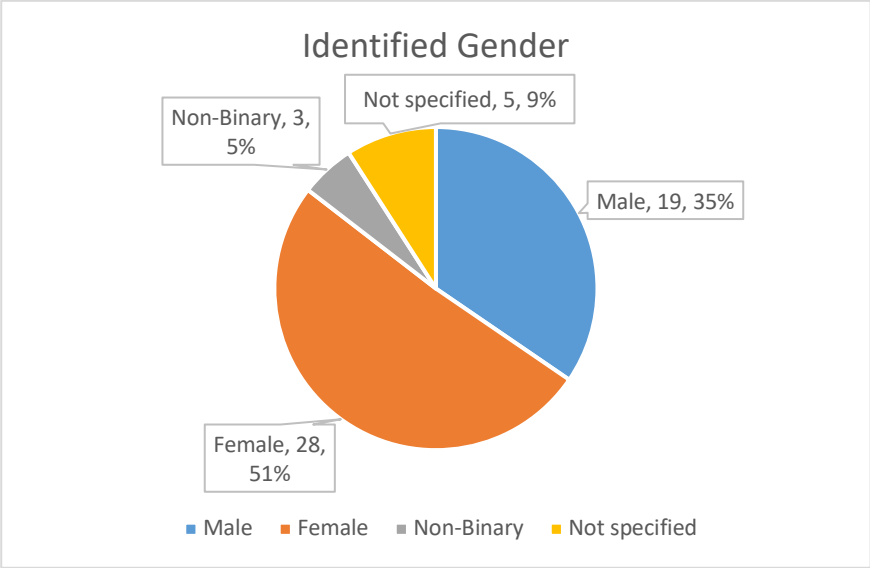
- Timeframes for the project have impacted a measured investigation and survey distribution
- Survey findings may not be able to be generalised to a meaningful population considering the respondents may not be representative of the general cohort
- The method of sampling may provide an over-representation of a particular set of respondents which cannot therefore represent the workforce population as a whole
- Sampling bias may be present and generalised to persons who are sufficiently interested to complete the survey

2.3 Demographics

2.3.1 Age Bracket



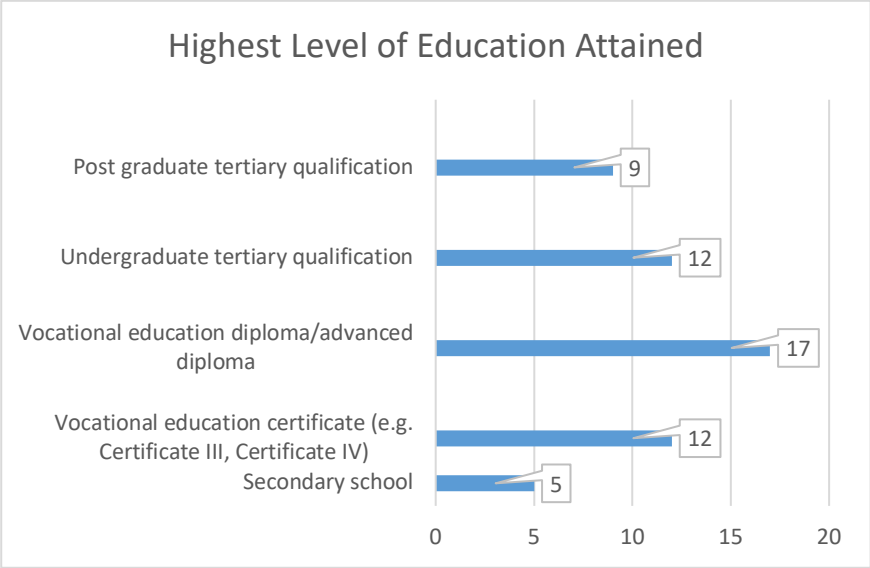
2.3.2 Gender



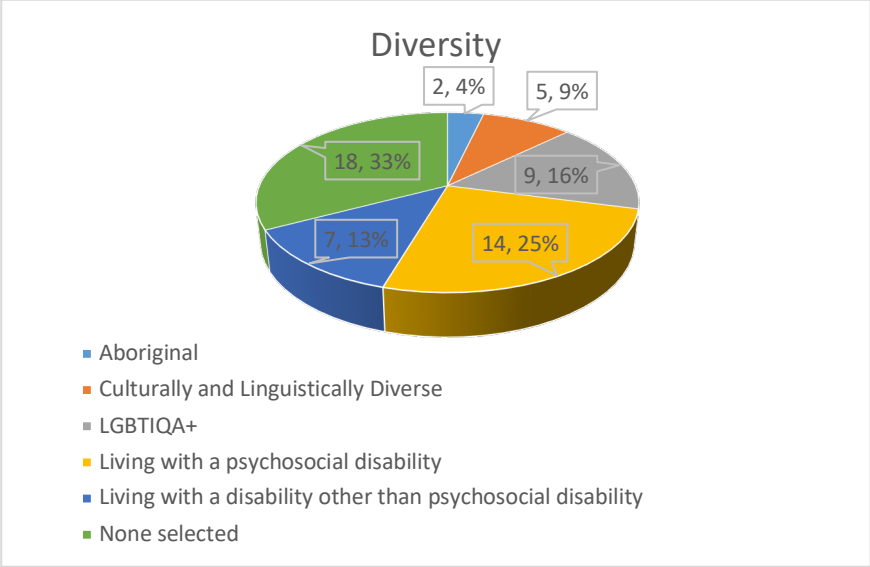
2.3.3 Employment Location

Other responses included both metropolitan and regional; unemployed; living regionally and working for Victorian, interstate and national projects; and unemployed but have applied for volunteer positions.

2.3.4 Highest Level of Education



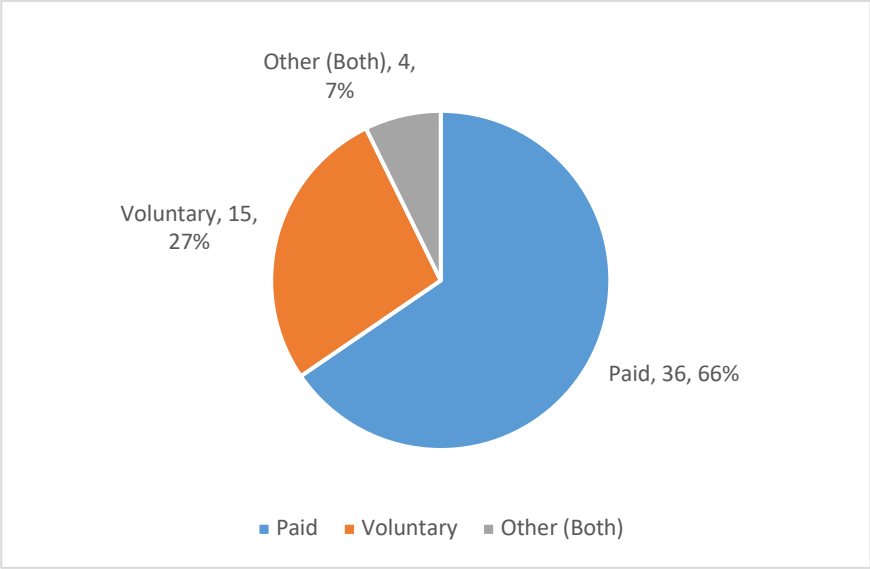
2.3.5 Cultural Diversity



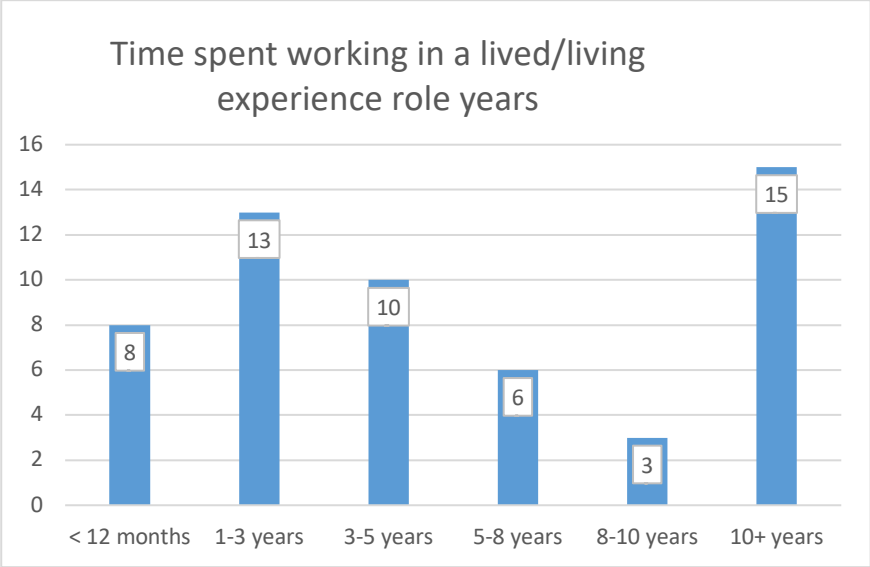
No survey participants identified as Torres Strait Islander or Refugee/Asylum Seeker

2.3.6 Role Type

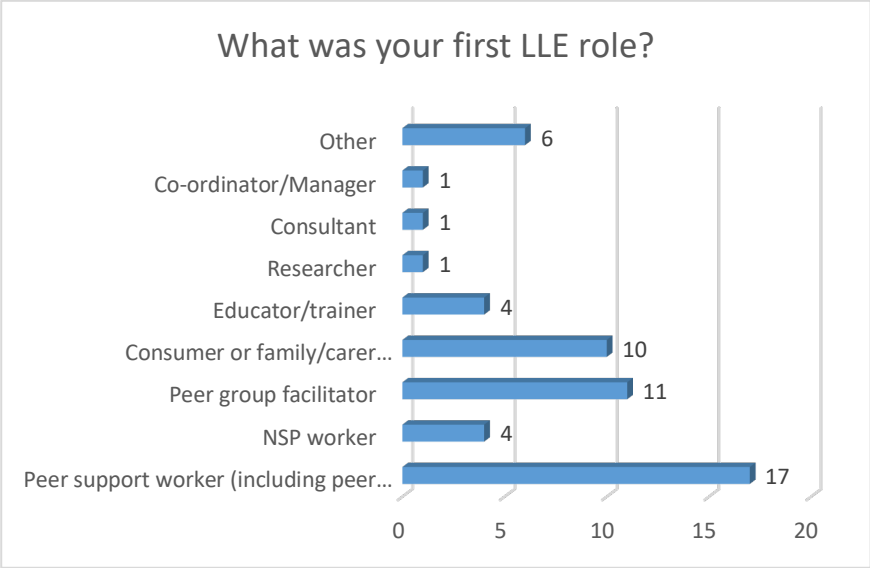
2.3.6.1 Paid vs Volunteer Role



2.3.7 Length of Time in LLE Roles

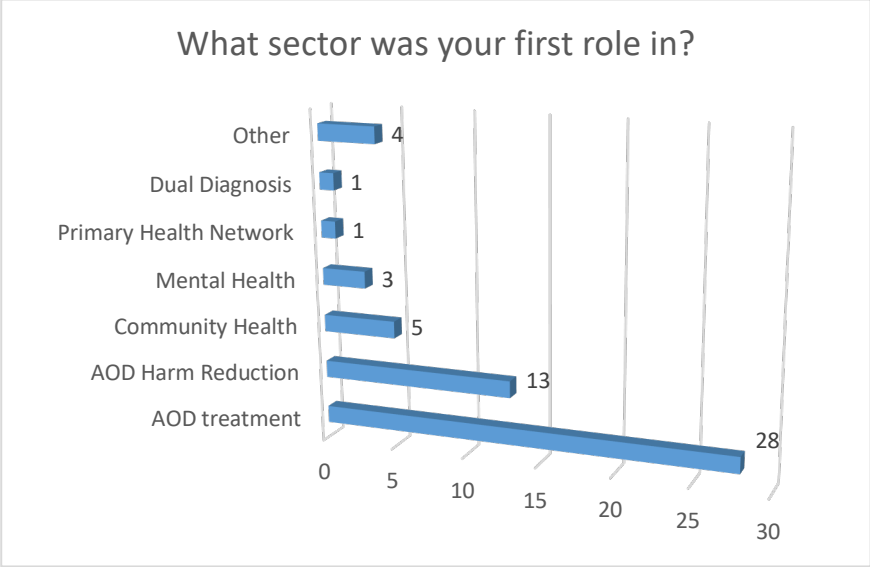


2.3.8 What Was Your First LLE Role



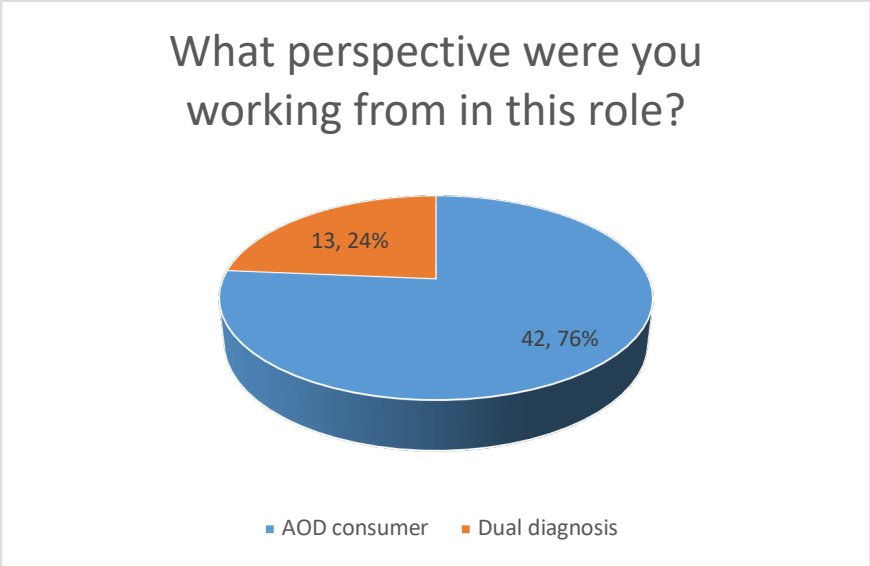
The 'Other' roles included Duty Worker, Therapist, Speaker, and someone working numerous roles.

2.3.9 Role Sector



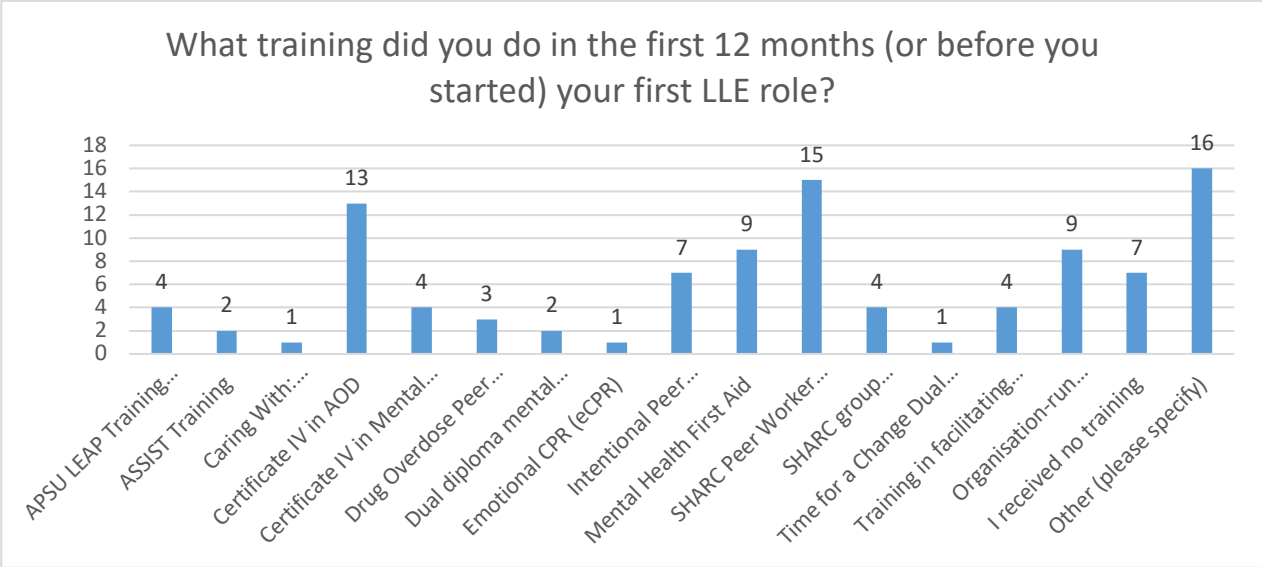
51 percent of the participants had their first LLE role in the AOD Treatment sector with 24 percent in the AOD Harm Reduction sector. The 'Other' type included AOD Consumer Participation, At Risk Youth, Education, All Areas.

2.3.10 Role Perspective



2.4 Training

2.4.1 Training Completed Within First 12 Months in Role



Percentage wise this is the breakdown.

What training did you do in the first 12 months (or before you started) your first LLE role?	Percentage
Other (please specify)	29.09%
SHARC Peer Worker Training	27.27%
Certificate IV in AOD	23.64%
Mental Health First Aid	16.36%
Organisation-run introduction to peer work training. If so, please specify your organisation in the "other" option	16.36%
Intentional Peer Support (5-day core skills)	12.73%
I received no training	12.73%
APSU LEAP Training (previously called Peer Helper Training)	7.27%
Certificate IV in Mental Health	7.27%
SHARC Group Facilitation training	7.27%

Training in facilitating peer groups	7.27%
Drug Overdose Peer Education	5.45%
ASSIST Training	3.64%
Dual diploma mental health and AOD	3.64%
Caring With: orientation to carer lived experience work	1.82%
Emotional CPR (eCPR)	1.82%
Time for a Change Dual Diagnosis LEW training	1.82%

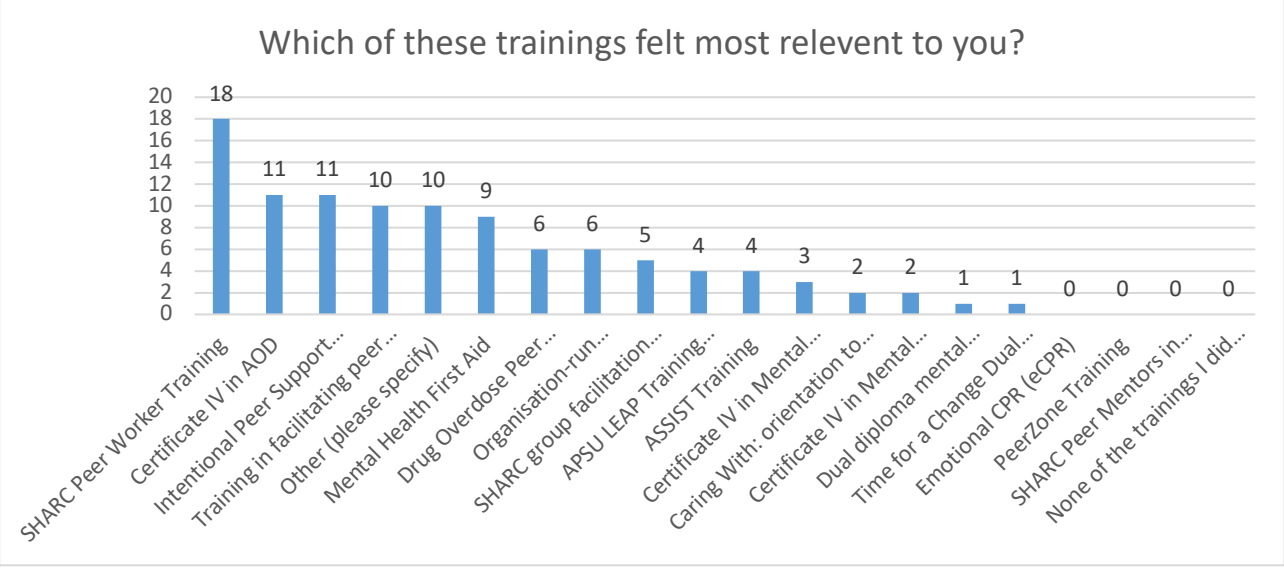
Multiple respondents participated in multiple trainings within, or before, their first 12 months in their first LLE role.

'Other' included Narcotics Anonymous, Workplace Trainer & Assessor, Nexus Before During and After (BDA) Harm Reduction, Needle and Syringe Program (NSP) training, Becoming Trauma Informed, Integrating Motivational Interviewing (MI) & Cognitive Behavioural Therapy(CBT), No To Violence (NTV) Assertive Interventions, HIV and Working with Affected Communities and individuals, Diploma of Community Services, Certificate III in Community Services, APSU Public Speaker Bureau training, Uniting AOD Consumer Participation Training, and training at a health centre.

No survey participants had completed the following training:

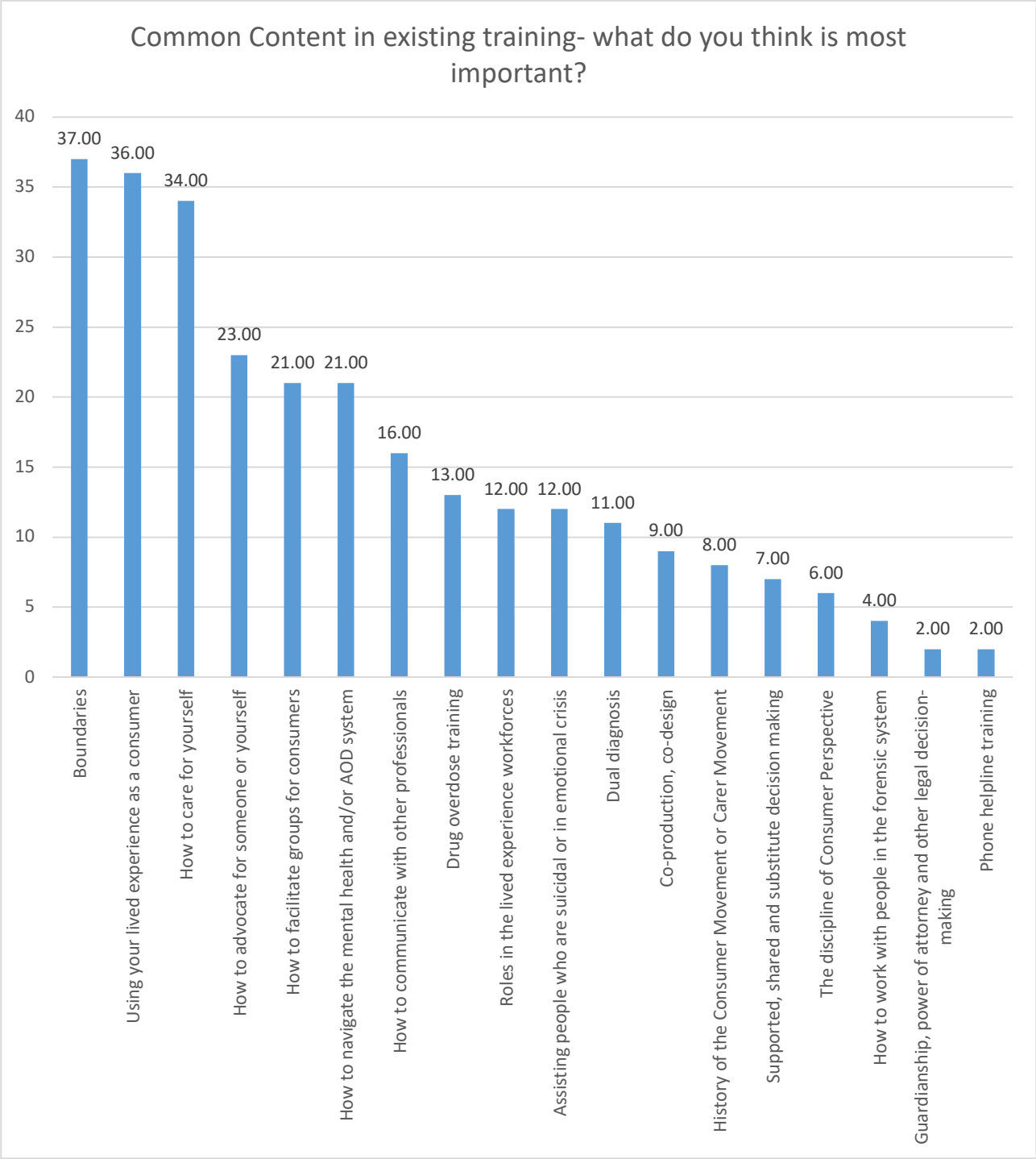
- SHARC Peer Mentors in Justice Training
- PeerZone Training
- Foundations of Peer Work (Mental Health Victoria/Vicserv)
- Certificate IV in Mental Health Peer Work

2.4.2 Which of these Trainings Felt Most Relevant to You

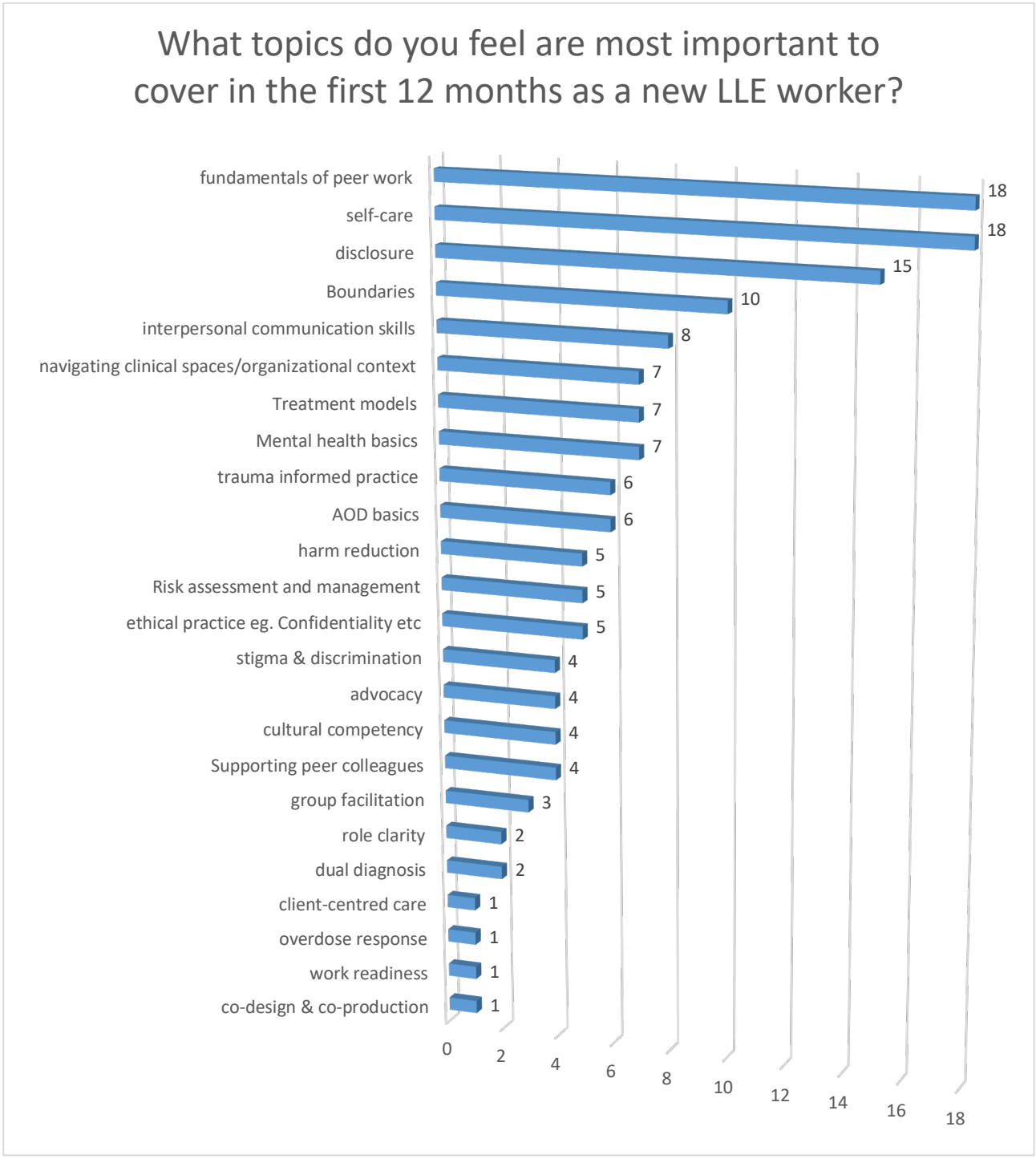


'Other' included Nexus Harm Reduction, Narcotics Anonymous, student placement, Hepatitis Victoria Speaker Bureau, Occupational Health & Safety, and Certificate IV in Community Services

2.4.3 Topics in Existing Training Considered Most Important in the First 12 Months

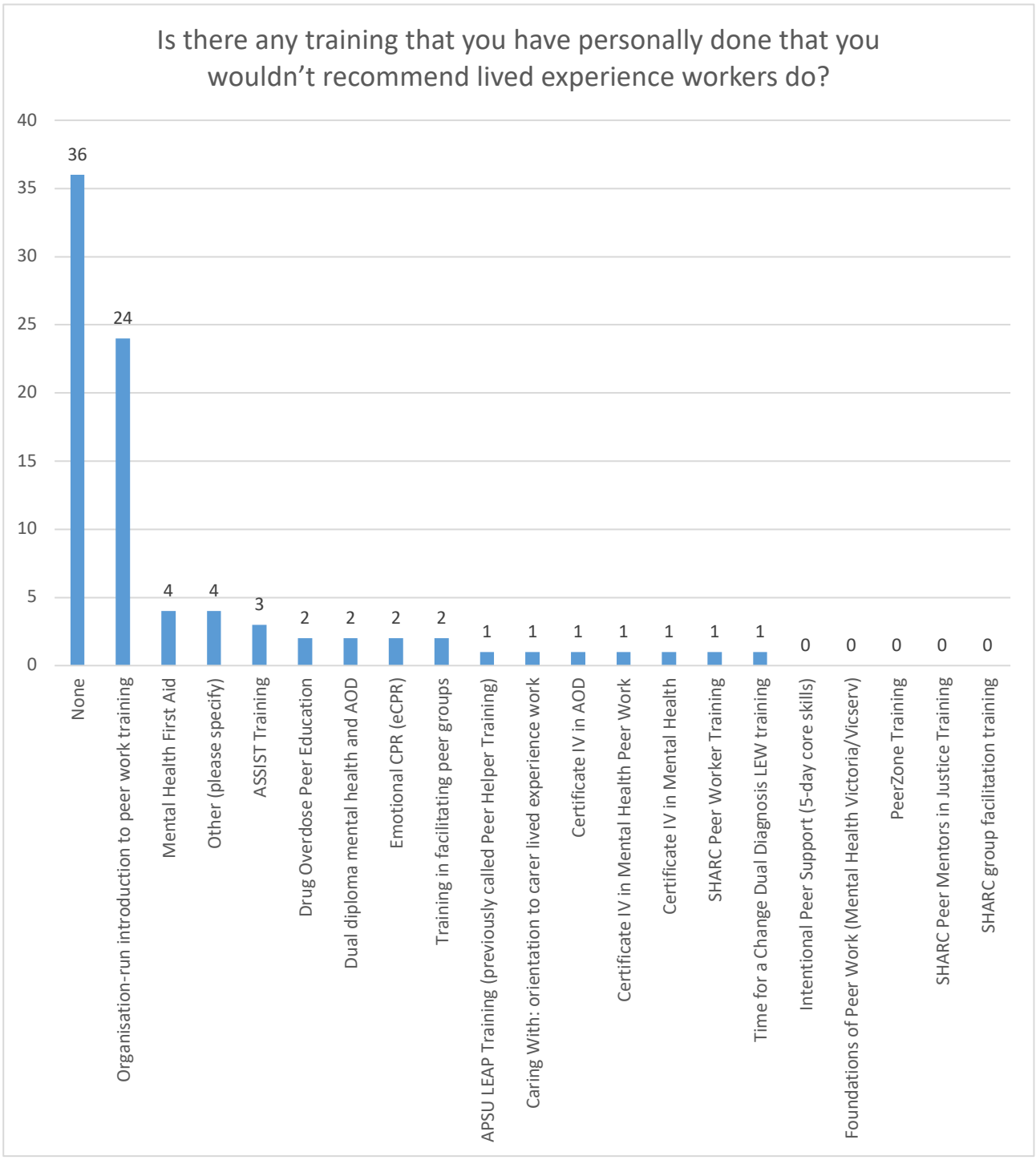


2.4.4 Topics Thought Most Important in First 12 Months of the Role

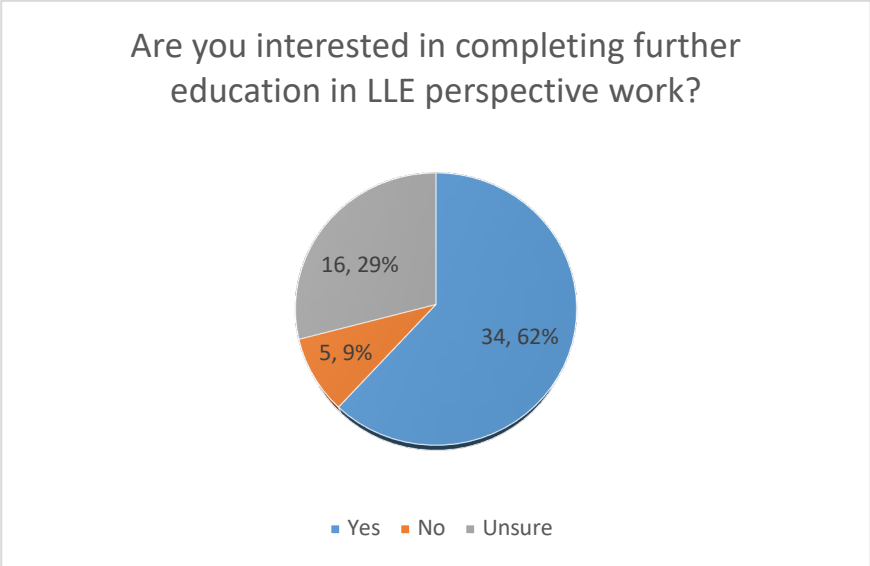


2.4.5 Training Not Recommended for LLE Work

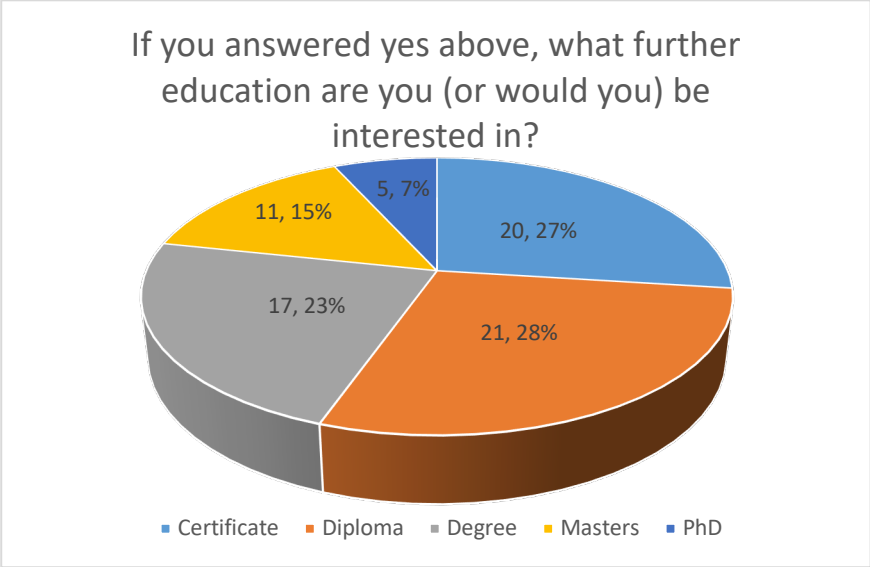
Participants were asked if there was any training that they've done that they wouldn't recommend for LLE work.



2.4.6 Interest in Completing Further Education in LLE Work

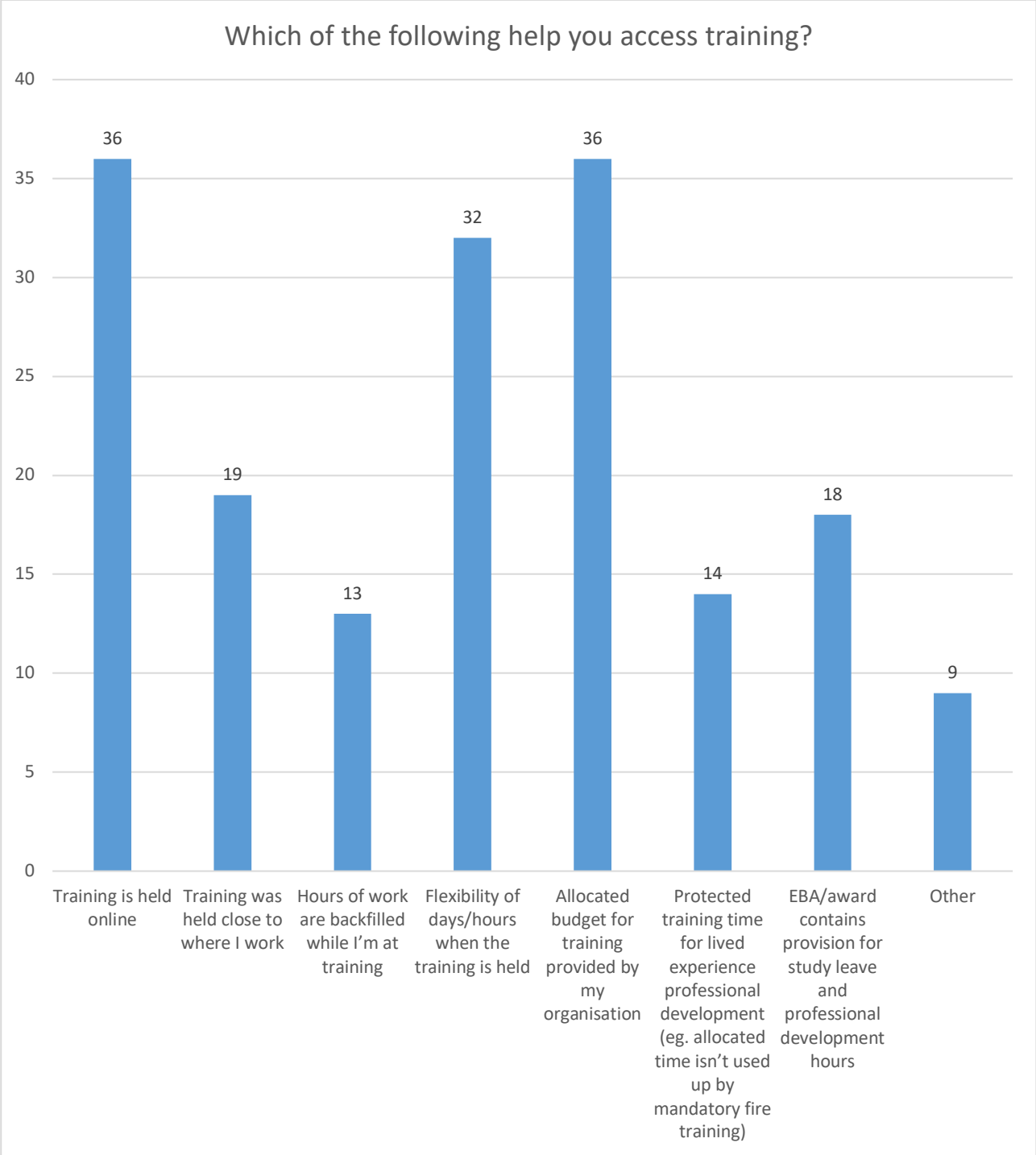


If participants answered yes, they were then asked what type of education they would be interested in.



2.5 Participation and Access

2.5.1 What Helps You to Access Training

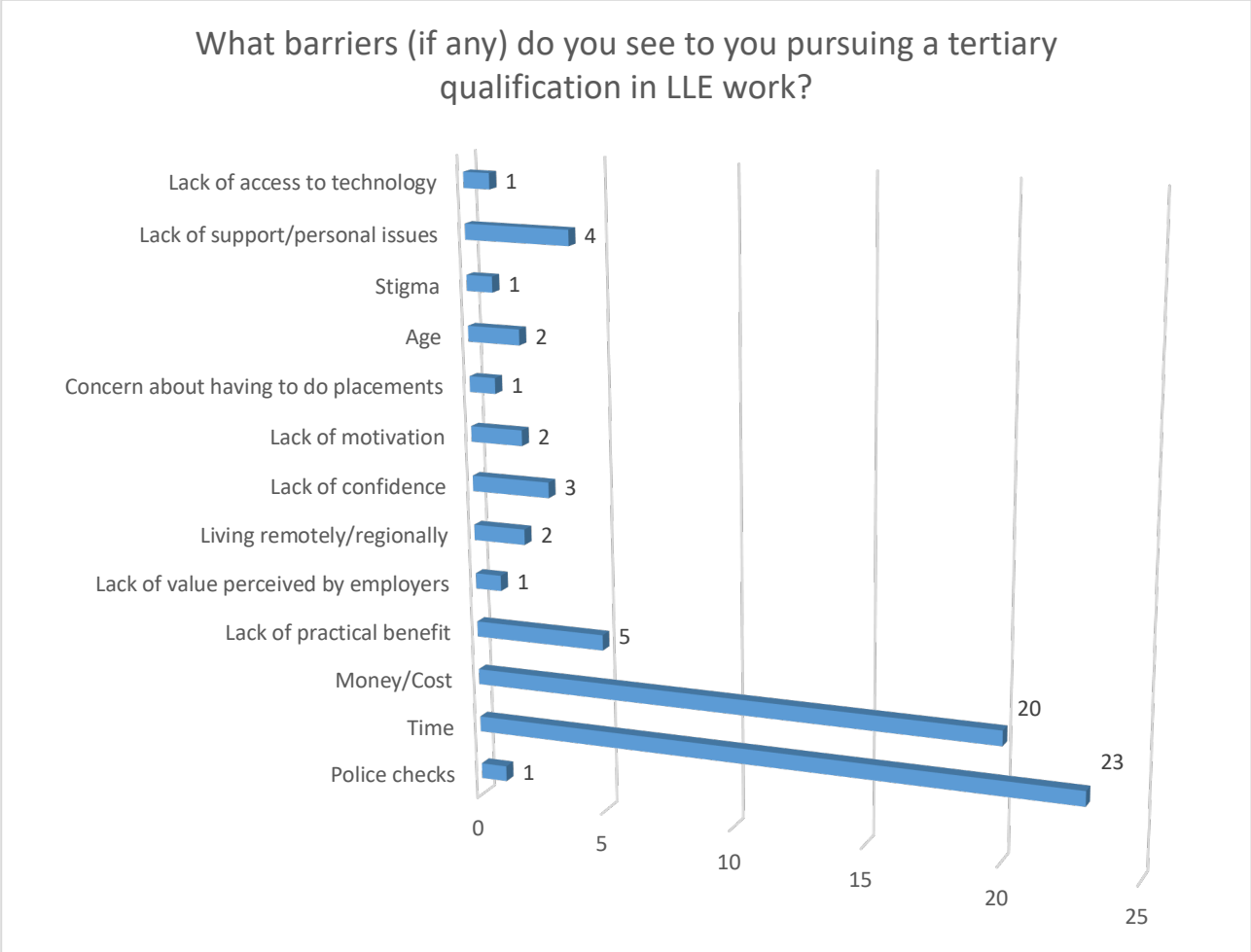


'Other' includes having financial incentives/ being paid to attend training, management support/encouragement and training being recommended by the workplace.

2.5.2 What Makes it Harder to Access Training

'Other' includes lack of flexibility of training modalities, days and times; not being paid to attend training, training not being offered to people in part-time employment, lack of management support to attend training.

2.5.3 Barriers to Participation in Training



3 Focus Group Findings

3.1 Focus Group Parameters

1. Participants – Who did we have in the focus groups?

We conducted 4 focus groups consisting of AOD consumer LLE experience workers from a variety of environments and services. All participants were either recently or currently in AOD consumer LLE roles. There were a total of 29 participants.

2. Recruitment – How were the participants recruited?

Firstly, we sent through information about the "*Our Future*" project, including links to the survey and focus groups, via various LLE networks including Victorian AOD Peer Workforce Community of Practice via Basecamp (an online platform funded by DHHS), VAADA, the SHARC community, APSU members, Peer Project's mailing list, past peer worker training participants, other organisations and LLE workers to whom we provide supervision and/or training services.

3. Data collection – How was focus group data collected?

We presented a PowerPoint presentation which we shared through Zoom online video conferencing. The power point presentation featured slides with key questions for participants to answer. Each participant had an opportunity to speak and was also given the option to use the chat function on Zoom.

We asked for consent to record the session and, once received, we commenced recording. As each participant spoke and used the chat function, we took notes for each question using the initials of participants to specify who stated what so that we could review for specific quotes if not noted at the time.

As part of each focus group, we incorporated a tool of creating a "live" list in which we gathered feedback as to what subject matter was important to include in future training models. This data was collected and collated in a model for AOD Consumer LLE workforce training.

4. Data analysis – How was the data analysed? What were the data findings e.g. % of participants who felt that boundaries are an important topic for LLE workers?

At the completion of all focus groups, we gathered our notes, highlighted key themes and categorised the input provided in table form. The table showed key themes with subject matter that was raised and discussed by focus group participants; key quotes were also included. Data percentages were calculated across key themes and subject matter. We then gathered the data to offer recommendations based on learnings from focus group participants.

3.2 Key Statistics from the Focus Groups

3.2.1 Boundaries

59% of participants spoke directly about the importance of the inclusion of boundaries in LLE workforce training, however, it was noted that the majority of participants were in agreement, therefore, the percentage is not a true reflection of this consensus.

Key statements captured in the groups:

"I didn't know if I was a mate, or was I a professional."

"…need to know the importance of understanding the difference of helping and not saving."

"It can be really hard to sit back and watch them (consumers) fumble through things instead of jumping in to save them."

"…Understanding the importance of doing 'with' and not doing 'for' consumers was the most fundamental shift for me."

3.2.2 Trauma-informed Care

52% of participants spoke directly about the importance of the inclusion of trauma-informed care and vicarious trauma in LLE workforce training, however, it was noted that the majority of participants were in agreement, therefore, the percentage is not a true reflection of this consensus.

3.2.3 Purposeful Disclosure

45% of participants spoke directly about the importance of the inclusion of purposeful disclosure in LLE workforce training, however, it was noted that the majority of participants were in agreement, therefore, the percentage is not a true reflection of this consensus.

Key statements captured in the groups:

"It's important to learn how to be interested rather than interesting."

"It was important to understanding my own lived experience and making sense of it."

3.2.4 Self-care

41% of participants spoke directly about the importance of the inclusion of self-care in LLE workforce training, however, it was noted that the majority of participants were in agreement, therefore, the percentage is not a true reflection of this consensus.

3.2.5 Stigma

24% of participants spoke directly about the importance of the inclusion of stigma in LLE workforce training, however, it was noted that the majority of participants were in agreement, therefore, the percentage is not a true reflection of this consensus.

Key statements captured in the groups:

"There can be shame attached to lived experience work and feeling like a second class citizen because you're in recovery."

"In battling stigma it's important to learn how to put that into words without being disrespectful and argumentative. Standing up to say that's not on."

"There's a real need to be treated professionally."

3.2.6 Recovery Models and Recovery Capital

17% of participants spoke directly about the importance of learning about different models of recovery, inclusive of recovery capital, in LLE workforce training, however, it was noted that the majority of participants were in agreement, therefore, the percentage is not a true reflection of this consensus.

Key statements captured in the groups:

"Just because something worked for me, doesn't mean it will work for someone else."

"We're working with people where they're at, not with where we're at. It's important to understanding different recovery models."

3.3 Key Core Content Areas Identified

This section contains content areas from across the AOD Consumer focus group analysis and incorporates qualitative survey data.

These areas match high-level content topics as per the AOD Consumer Core Learning Objectives Model.

The following learning objectives were identified:

- To gain detailed understanding of the LLE workforces
- How to apply LLE within formalised settings
- To understand core concepts and competencies of the LLE disciplines
- To explore key components of various roles, increase confidence and develop skills in communication and navigating relational parameters
- To increase understanding of ethical practice and diverse service delivery

- To empower workers to advocate for their discipline and manage their own wellbeing and development needs

3.4 Understanding the LLE Experience within the AOD Service System

This section outlines the chapter level subjects that were identified as necessary in AOD LLE training. Each chapter level then expands into the topics and sub-topics.

3.4.1 Purpose, History, Principles and Values

- Defining LLE work and its purpose
- Understanding where LLE work fits within the AOD service system
- History and evidence base of the AOD and MH LLE workforce
    - Outcomes and benefits
    - Stigma, discrimination and consumer movements
    - Importance of language
    - The strategy for the AOD peer workforce in Victoria (2019)
    - Vision for the Victorian AOD peer workforce
    - Victorian AOD Peer Workforce Community of Practice
- LLE values and principles
- Navigating the AOD service systems
    - Types of services available
    - Diverse approaches i.e. harm reduction and abstinence
    - Understanding different LLE frameworks and methods
    - Collaborative approaches
- Difference from clinical / non-LLE roles and how they can work together

3.4.2 Alcohol and Other Drugs

- Understanding the Victorian service system and Victorian treatment streams
- Why do people use alcohol and other drugs?
- Different types of drugs and drug use
- Dual diagnosis
    - Understanding comorbidity including MH, family violence, suicide
- Stages of change model
- Understanding different practice types:
    - Recovery-oriented practice and treatment principles
    - Strength-based practice
    - Harm reduction values and principles

3.5 LLE in Practice

3.5.1 Roles and Key Concepts

- Types of AOD LLE roles
    - Group facilitation
    - Advocacy
    - Peer work
    - Advisory and consultant roles
    - Overdose prevention
    - NSP
    - Leadership (Supervisors, team leaders and coordinators)
- Better Practice
    - Victorian AOD Peer Workforce Core Competencies
- Self-determination
- Doing with vs doing for

3.5.2 Using Our LLE

- Purposeful Disclosure
    - Making sense of 'our story' and how it shapes our work
    - Editing 'our story'
    - Limits of sharing your lived or living experience
    - Sensitive areas
    - Managing triggers
    - How and when to use your own experiences
    - Preparing to be 'known'

3.5.3 Working with Others

- Boundaries
    - Types of boundaries (physical, emotional etc.)
    - Professional and personal boundaries with service users and colleagues
    - Conflicts of interest and dual-relationships
- Trauma informed care
- Recovery capital – understanding available resources

3.5.4 Communication

- Effective communication and understanding language
- Types of communication
    - Verbal and non-verbal
- Active Listening
- Assertiveness
- Conflict resolution and diplomacy
- Psychological safety in the workplace

- Challenging power imbalances
- Having difficult conversations
- Barriers to communication
- Motivational interviewing through a peer perspective

3.5.5 Diversity, Inclusion and Ethical Practice

- LLE perspectives on AOD
- Stigma and discrimination
- Cultural competence
- Ethical standards and practice
- Ethical dilemmas (personal and professional)
- Understanding the overlap between AOD and MH (Dual diagnosis)

3.6 Working in Formalised Settings

3.6.1 Working in Clinical and Forensic Settings

- Introduction to working as a professional i.e., expectations in a clinical or forensic environment around attire, punctuality, organisational skills and professional conduct
- Working within a multidisciplinary team
- Understanding other roles
- Understanding how to deal with stigma in the workplace
- Role advocacy and scope of practice
- Understanding power dynamics in peer relationships and clinical hierarchies
- Referral processes – promoting referral pathways to LLE workers; knowing how to refer as a LLE worker, the different pathways etc.
- How to practice values and principles of LLE work within a clinical setting
- Working collaboratively
- Critical incident management
- Understanding MH Sector and MH Act 2014

3.6.2 Safety, Risk and Legislation

- Confidentiality and privacy
- Duty of care
- Informed consent and disclosure
- Understanding governance and legislation
- Organisational policy and procedure
- Understanding and managing risk and what to hold
- Dignity of risk
- Case noting
    - Co-writing case notes
    - Differences between LLE case noting and clinical case noting

3.7 Wellbeing, Personal and Professional Development

3.7.1 Self-care

- Self-care education and tools
- Vicarious trauma
- Well-being tools
- Reflective practice

3.7.2 Supports

- Role challenges
- Role supports: debriefing, supervision (and how to use it)
- Your rights and reasonable adjustments
- Networking (Communities of Practice, co-reflections)

3.7.3 Professional Development

- Career planning/trajectory
- Professional development
- Peer drift – what it is and how we can we identify it
- Volunteering, mentorship and placement opportunities

3.8 Advocacy for the LLE Workforce

3.8.1 Champions for Change

- Understanding consumer rights
- Advocacy and promotion of LLE work
- Understanding drivers of change
- "it's not about what we do but how we do it"
- Importance of staying informed about LLE initiatives across sectors
- Advisory/Consumer Advisory Groups (CAGs) groups
- Fair work rights i.e., Enterprise Bargaining Agreements (EBAs), benefits and entitlements, advocating for fair role capacity

4 Barriers to Training

Barriers to training were raised in both the focus groups and surveys. The central themes were based around access, both regarding time and/or cost. This related to existing training options but was also a concern for future options being affordable and flexible.

Another issue raised was support from managers, particularly if they didn't have their own lived/living experience, which resulted in a lack of understanding or willingness to support engagement with training.

5 Additional Supports Post-Training

Both the focus groups and surveys identified a number of additional supports required beyond initial training. These can be summarised into the following categories:

- Organisational readiness – this supports a number of objectives such as role clarity, team awareness, development of LLE opportunities beyond peer work.
- Supervision – the need for discipline-specific supervision was identified across the groups as a vital component of the LLE workforce. The need for both supervisors and supervisees to have a thorough understanding of supervision in a LLE context was also raised to ensure that they got the most out of it as possible.
- Mentoring/placement opportunities – again the opportunity to get experience within agencies was identified as valuable for both the LLE workforce and the agencies employing them.
- Networking – the opportunity to immediately network with other AOD LLE workers. The Victorian AOD Peer Workforce Community of Practice is one such opportunity.

6 AOD Consumer Specific Recommendations

Based on the collection and analysis of the 4 focus groups and 55 survey responses, we have the following recommendations:

1. Training to be delivered to LLE workers in the first 12 months, either at the beginning or prior to beginning their role.

Many participants of the focus groups referred to their first year as "being thrown in the deep end".

One participant stated "Everyone was looking to me, while I was still learning my role."

One participant stated in reference to having no training in first year; "… we pretty much had to feel our way through it".

2. Training to be delivered and facilitated by a combination of both lived and living experience AOD workers who have extensive experience in a variety of settings in the AOD workforce along with relevant qualifications.

3. The AOD lens IPS training to be funded to develop and deliver an online version.

One participant stated "IPS is probably the thing that saved me, I had something to lean on."

4. Training to have specific focus on core components as identified from focus group data including; purposeful disclosure, role clarity, boundaries, diverse perspectives of recovery models and recovery capital, trauma-informed care through a LLE lens, vicarious trauma, self-care and stigma.
5. Training to include significant understanding of a variety of roles within the LLE workforce including peer work, group facilitation, advisory, committee and advocacy roles, LLE specific supervision and leadership.

One participant stated "Professional supervision is really valuable."

Another participant stated "Committee roles keep me connected with services and the field and what's going on."

6. AOD specific LLE training to cover both harm reduction and treatment services, detailing the differences as well as the similarities in approaches.
7. Training to be delivered with capabilities of being facilitated and delivered in person as well as online.
8. Training to explore different styles of learning and ways to diversify training opportunities.

One participant stated "I feel like our lived experience qualifies us, we don't need formal training, formal training can be a barrier."

9. Organisations implementing a LLE workforce to undergo Organisational Readiness Training and make a commitment to continuous understanding, improvement and review.

One participant stated "Not being supported in the space led to me wanting to be in a leadership role."

One participant stated they felt that other staff were saying "What is this person doing here?" referring to a lack of organisational understanding, and that multidisciplinary staff were confused about the peer role in the first year.

10. Training to assist participants with placement or volunteer opportunities for work experience.

One participant stated without placement opportunities they felt "left in the wind".

One participant stated the importance of shadowing someone who already had experience in the role as they were "pioneering the way".

One participant emphasised the importance of shadowing "someone who knew what they were doing".

11. Training to include components of work readiness such as basic I.T skills, resume writing, professional conduct and understanding of organisational policy and procedure.

One participant stated the importance of "work readiness" stating they had witnessed other lived experience workers struggle in roles they were not ready to work in.

12. Training to include an emphasis on dual diagnosis, mental health as well as other associated LLE workforces such as homelessness and gambling harm.

Appendix 6: Mental Health Family/Carer Consultation Report and Content Outline

Authors:

Lorna Downes, Family/Carer Workforce Development Coordinator, CMHL

Katrina Clarke, Carer Lived Experience Workforce (CLEW) Chair, Family/Carer Consultant Expert

Jacqui Hill, Family/Carer Workforce Development Coordinator, CMHL

Partner organisations:

Centre for Mental Health Learning and Carer Lived Experience Workforce Victoria

Contents

Mental Health Family/Carer Lived Experience Workforce

The following section is informed by three key elements:

- Family/carer lived experience workforce expertise from the Our Future CLEW Advisory Group members, including Our Future Project MH Family/Carer Consultants and Knowledge Experts
- Analysis of survey responses from mental health family/carer respondents
- Analysis of mental health family/carer focus group transcripts

Our Future LEW Training CLEW Advisory Group

The Carer Lived Experience Workforce Network (CLEW) is a long-standing, strong, volunteer-run network for people working in family/carer workforce roles in Victorian mental health services. The Carer Consultants Network of Victoria (CCNV) was established in 2001 with a few members, building to 31 active members by 2009. CCNV operated independently until the Mental Health Carers Network of Victoria (now known as Tandem) became an incorporated body in 2009, and auspice arrangements were established to support the CCNV. The CCNV was renamed CLEW in 2017 to acknowledge the growth and diversification of membership to include not only consultants but also family/carer workers employed in a variety of different roles. CLEW received secretariat support from Tandem until 2019 when secretariat and professional development forum support was transferred over to the Centre for Mental Health Learning (CMHL).

The CLEW has since grown substantially and now has 138 active members, including many of the founding CCNV members. The activities of CLEW include bi-monthly members' meetings, group co-reflective supervision, annual 2-day professional development forums, online community of practice for connecting between meetings (Basecamp) and opportunities to have a voice on issues that affect families, carers and the family/carer lived experience workforce.

Although family/carer workers have been employed in publicly funded mental health services since the late 1990's, there is extremely limited information about the work of the family/carer lived experience workforce in either formal or grey literature. Additionally, there is almost no training designed by, and for, the Mental Health Family/Carer Lived Experience Workforce about their roles and duties, whereas there is a considerable body of literature articulating the Consumer Lived Experience Workforce, and a range of training programs developed and delivered by consumer lived experience workers.

CLEW Leadership undertook work in 2018 to establish some of the foundational needs of the workforce starting with the development of the CLEW Values and Principles and was heavily involved in the creation of the Strategy for the Family/Carer Mental Health Workforce in Victoria (2019). Through 2019-2021, CLEW leadership has also invested in the development of the Carer Supervision Framework, Organisational Readiness Framework and tools, and now the development of the Carer Perspective Supervision Training.

In order to capitalise on the wisdom and knowledge of CLEW members, as well as to compensate for the lack of literature about the family/carer LEW discipline, involvement from CLEW members was sought by forming an Our Future CLEW Advisory Group.

Given the very tight timeframes for this project, there was limited time to undergo a full Expression of Interest process for the CLEW consultant and knowledge expert roles on the project. The CLEW chair had been involved in the project submission so it was decided, with the partners and with Tandem, that the CLEW Chair continue to be involved in the project as the CLEW consultant and knowledge expert, with support and advice from an Advisory Group. CLEW members were invited to be involved in the Our Future Project by completing the survey, attending the focus group, joining the Our Future CLEW Advisory Group and through the July and September members' meetings where the Advisory Group presented on the work following the Survey and advisory groups.

The Advisory Group consisted of 7 members including:

- CLEW Chair and Senior Carer Consultant at public mental health service
- 2 CMHL Family/Carer Statewide Workforce Development Coordinators
- LEW manager employed in a public mental health service
- Peer Support Coordinator employed in a public mental health service
- 2 Peak Body staff including regional and statewide specialist service sector perspectives

Although the Advisory Group had a wide range of experiences in different organisations and roles, there wasn't anyone currently employed in the community mental health sector (only 4 are reported to exist in the Lived Experience Workforce Report 2020) nor anyone currently employed in a rural service.

The Advisory Group met on 6 occasions throughout the project to provide input and feedback and to check assumptions, recommendations and report content. The Advisory group members also reported to and consulted CLEW members.

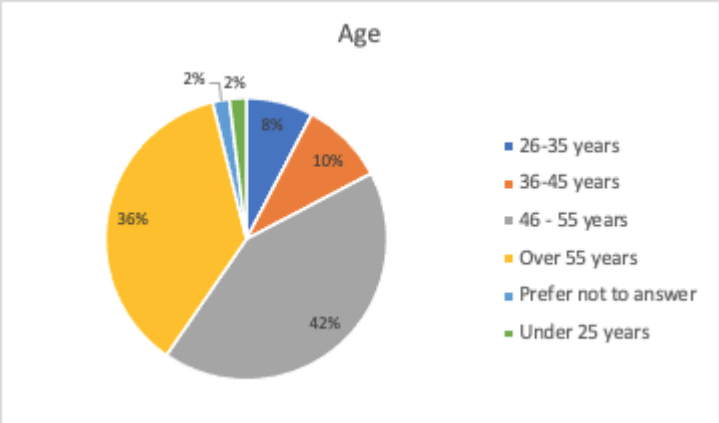
Advisory Group members were instrumental in testing the focus group layout and plan prior to focus groups and in providing support to participants during and after the 4 focus groups.

Survey Results

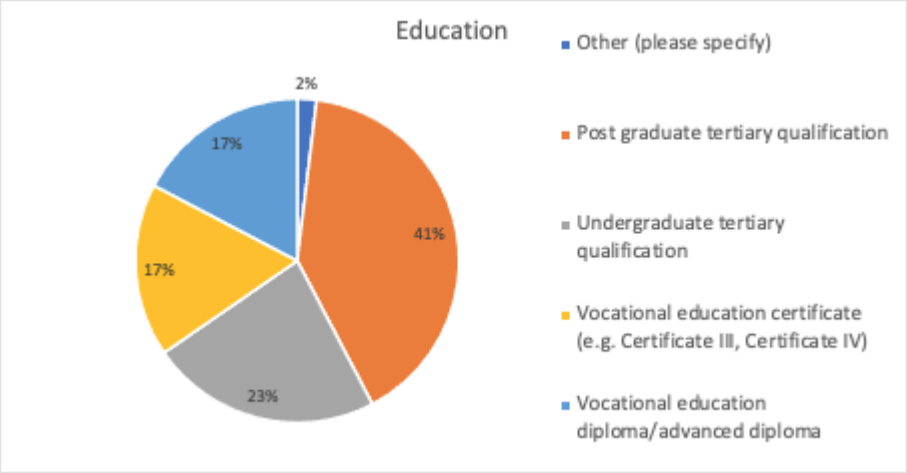
Demographics

Figures may not add to 100% due to rounding to the nearest whole number.

- 52 respondents
- 79% of respondents were over 46 years old (compared to the mental health consumer workforce where 47% are aged over 46 years and all cohorts combined where 56% were in the same age range. The number of AOD family/carer workforce was too small to provide a comparison).
- 96% female, (only 1 male and 1 not specified)
- 90% metropolitan



- 23% in an identified diversity category (Aboriginal, CALD, disability or LGBTIQA+)
- 10% of family/carer workforce also identify as having a psychosocial disability
- 63% have an undergraduate or post graduate degree



- Time in family / carer role most represented was 3-5 years (37%), least represented was 8 – 10 years (2% 1 person)

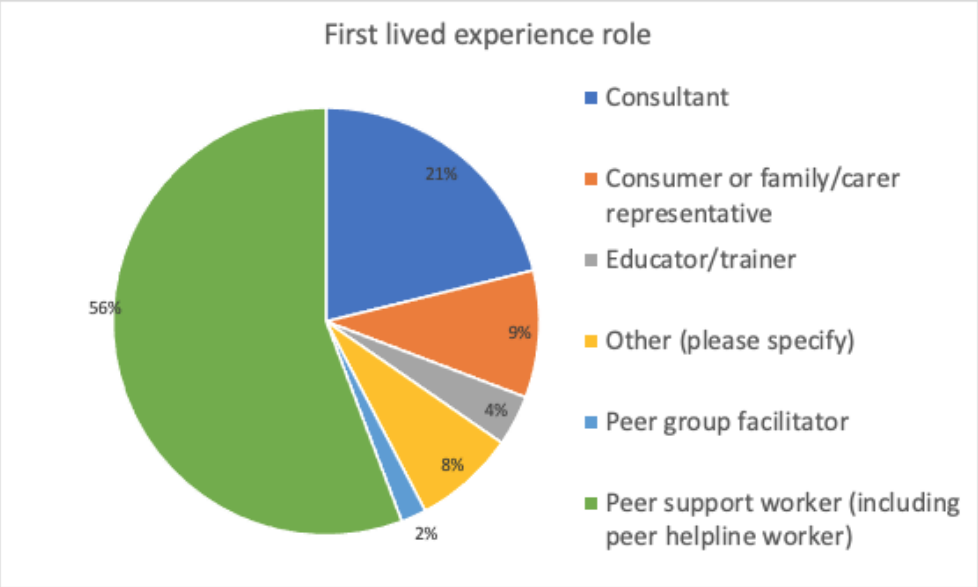
Training needs to be tailored to the very part-time nature of the workforce and allow for flexibility in enabling access and engagement in training for a workforce that is older, educated and multi-tasking across their community, home and workforce responsibilities.

The vast majority of respondents were working in metropolitan Melbourne. Entry-level training would need to encompass and reach out to the regional workforce to ensure equity of access. Because of low regional numbers, it's impossible to draw conclusions about what is needed for this workforce that may be different to their metropolitan based colleagues.

23% of mental health family/carer workers (FCWs) identified as being in one or more of the diversity categories. Training needs to be inclusive of these workers to ensure engagement in training. This group also represents a significant resource as they could contribute much to training other FCWs about diverse experiences and perspectives.

10% of respondents identified as having a 'psychosocial disability,' however, the CLEW Advisory Group members hypothesise that the number of family/carer workers who also have lived experience of mental illness/psychological distress and/or trauma is likely much higher. The survey, also, did not ask if consumer workers also identify as having family/carer lived experience. Whether or not people can, or should, work dual work roles (consumer and family/carer) or work across both perspectives in different roles is one that is contentious. Organisations may see benefit in having a workforce that has both consumer and family/carer lived experience however the consumer and family/carer workforces have been opposed to this due to the potential for tokenism, challenges with role clarity and abuse of power. Working in dual lived-experience roles is not recommended, however, there is value in exploring the different perspectives and advocacy messages of both groups as well as how having dual lived experience impacts on lived experience work in either a family/carer or consumer role.

First role

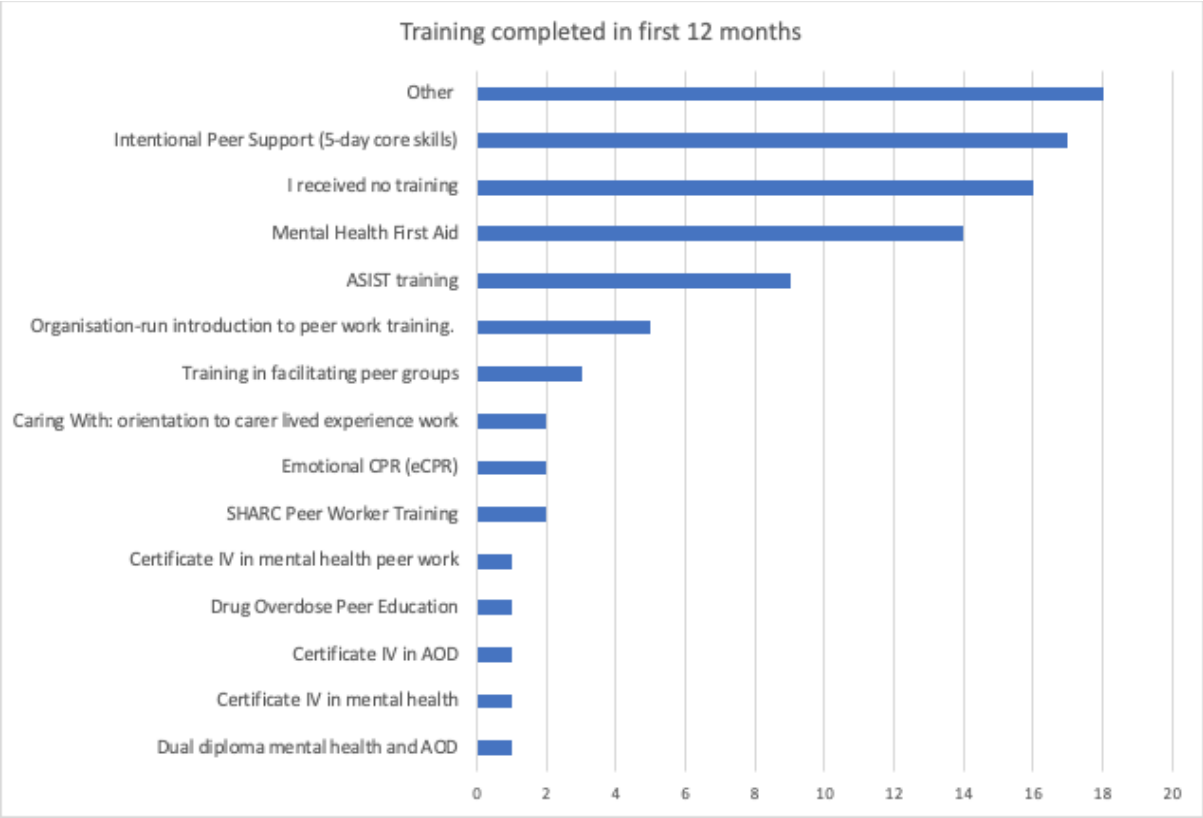


As the numbers were small, some of the categories have been reported together. Figures may not add to 100% due to rounding to the nearest whole number.

- 60% of respondents first role was peer support worker (including peer helpline worker and peer group facilitator)
- 21% first role was family/carer consultant
- 9% first role as a representative
- 10% first role was educator/trainer or other
- 58% first role was in an Area Mental Health Service (AMHS)
- 19% first role was in a Mental Health Community Support Service (MHCSS) or Non-Government Organisation (NGO)
- 12% first role was community service although it is not clear how people defined community service
- 88% first role was a paid role

The majority of family/carer workers first role is as a peer support worker however 40% of family/carer workers first role is in a role other than peer support. Although they did not complete the survey, the authors are aware that there are family/carer workers whose first lived experience role is as a manager/coordinator or policy officer. Therefore, entry-level training needs to be relevant to a range of different roles as well as provide options for learning the specialist skills inherent in the role they are undertaking.

Training completed in first 12 months



When asked *what training did you do in the first 12 months of (or before you started) your first lived experience role?* Importantly, 30% of respondents stated that they received no training in the first 12 months of their employment.

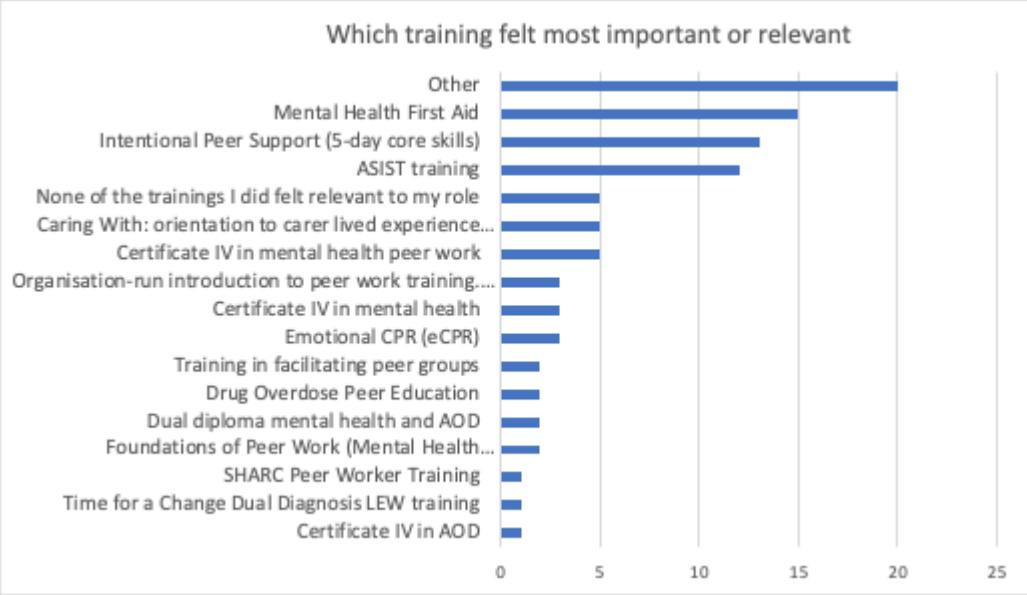
> *"Most training took place in my second year as I learned how to navigate and advocate for myself and identify what was relevant"* - Survey participant

The top 5 responses were:

- Intentional Peer Support (5-day core skills) 31%
- Mental Health First Aid 26%
- ASIST training 17%
- Organisation-run introduction to peer work training 9%
- Training in facilitating peer groups 6%
- 33% of respondents selected *"other, please specify"*. In these open-ended responses, there was no single training named that received more than one response. Responses were grouped according to broad categories:
    - Tertiary qualifications (n = 4)
    - Organisation run courses without specifics about the subject of the course (n=8)
    - Lived experience focused courses, which included courses about lived experience work and those led by people with lived experience (consumer or family/carer) (n=7)
    - Family centred practice courses (which included courses about working with families, parents or carers that were not lived-experience led) (n= 4)
    - Other short courses (n=3)

Caring With, eCPR and SHARC Peer Worker Training were selected by 2 participants each (4%). Of these trainings, only Caring With is designed and delivered by, and for, the family/carer lived experience workforce.

The survey identified that of those who had completed any training in the first 12 months, 48% completed some training in "peer work" although it's not clear here whether the term is being used to denote lived experience work generally, or peer support work specifically. For example, the Certificate IV in Mental Health Peer Work is a generic lived experience course. Of the courses mentioned, only Caring With (CW) and Single Session Peer Work (SSPW) were written specifically with family/carer workers in mind. 2 out of 36 respondents had completed CW and 1 out of 36 had completed SSPW in their first 12 months.



When asked *Which of these trainings felt most important or relevant to you?* the top 5 responses were:

- Mental Health First Aid 28%
- Intentional Peer Support (5-day core skills) 24%
- ASIST training 22%
- Caring With 9%
- Certificate IV in mental health peer work (9%)
- 9% selected *'none felt relevant to my role'*
- 37% of respondents selected *"other, please specify"*. In these open-ended responses:
    - 4 respondents stated '*informal learning' (*mentoring, on the job).
    - 2 respondents stated '*parts of IPS'*.
    - There were no other courses which received more than one response in the open ended responses.

> *"Intentional peer support was very heavily focused on consumer work however I felt it gave me a good understanding of understanding World views, connecting with a carer and understanding the difference between helping and moving towards. A modified version that caters more to carer needs would be helpful. (sic)"* - survey respondent

Participants were asked *Please describe why the above training felt the most important or relevant to you?* Open-ended responses were grouped according to similar themes and the top categories were:

- 11 responses related to relevance to the role with 5 stating the training was relevant to a family/carer role specifically
- 6 responses related to the training being practical or helpful - providing frameworks, strategies and tools
- 5 responses related to understanding the diversity of family/carer experiences
- 6 responses related to working with people who are distressed, of which 4 responses specifically mentioned working with people at risk of suicide or supporting people caring for someone at risk of suicide
- 4 responses directly mentioned IPS tasks and principles such as connection, worldview and helping vs fixing
- 3 responses stated that it was relevant *'because it was offered'*

Although 24% of people said IPS was relevant, 6% of respondents also said they would not recommend IPS. In order to explore why survey respondents would recommend IPS, open-ended responses from people who chose IPS training as relevant or important and no other training were examined. Responses are listed below:

- *"I identify strongly with the ethos and principles of IPS"*
- *"It was the only training I have been offered"*
- *"The IPS 5 day core training is the only training I did for my role, but it was relevant because it provides you with a framework on how to build and maintain a connection with persons that may have a different world view."*
- *"changing role from non peer carer support to carer peer support - ability to clearly define new role"*
- *"Training that was specific and practical to peer work - however, not specific to carer lived experience peer work"*
- *"it was grounding and promoted true peer support"*

Training needs in the first 12 months

Participants were asked to *Pick up to five that you think are the most important topics for new lived experience workers to understand* from a list of common content across current entry-level training for lived experience workers in Victoria sourced from the desktop audit of currently available trainings.

- 5 top topics were:
    - using your lived experience
    - how to care for yourself
    - how to navigate the mental health or AOD system
    - boundaries
    - how to advocate for someone or yourself
- The discipline of Consumer or Family/Carer Perspective was in the top 6 overall and in the top 5 important topics for those newer to the workforce (<12 months - 3yrs)
- How to advocate for someone or yourself was in the top 5 for people in the workforce >10yrs
- Using your lived experience was selected as the most important topic for all family/carer workers in all workplaces except those in Primary Health Networks (PHNs) (although the number of respondents in PHNs is too small to be reliable).
- Those working in AMHS selected as their top 5 topics:
    - Using your lived experience 83%
    - How to navigate the mental health and or AOD system 70%,
    - How to care for yourself 67% ,
    - Boundaries 47%,
    - How to advocate for someone or yourself 43%
    - How to communicate with other professionals 43%
- Those working in Mental Heath Community Support Services (MHCSS)/Non-government Organisations (NG0s) and Peak Bodies selected as their top 5 topics:
    - Using your lived experience 83%
    - Assisting people who are suicidal 75%
    - How to care for yourself 67%
    - The discipline of Consumer or Family/carer Perspective 50%
    - How to advocate for someone or yourself 50%
    - How to navigate the mental health and or AOD system 50%
    - Boundaries 50%
    - How to communicate with other professionals 9%
- Those working in Community, Primary Health and ‘other’ selected as their top 5 topics (nb numbers very small)

- Boundaries 90%
- Using your lived experience 80%
- How to care for yourself 80%
- Coproduction, codesign 5, advocacy 60%,
- How to navigate the mental health and or AOD system 60%
- How to advocate for someone or yourself 60%
- The discipline of Consumer or Family/Carer Perspective 40%

Despite the variation in workforce numbers across the different system settings, there was high consistency in the top 5 identified topics.

This section of the survey highlighted a broad consistency in identified top 5 training needs. There were some notable differences between workplace settings. E.g. of those working in MHCSS/NGO, 75% respondents identified the topic " assisting people who are suicidal" as a priority area. This was not identified by those in other settings, notably AMHS. CLEW Advisory Group Members hypothesised that this may be because those working in community services are more likely to be supporting families/carers of people who are suicidal and experiencing difficulties accessing clinical mental health services. In addition, CLEW Advisory group members highlighted that family/carers are less likely to communicate their own thoughts of suicide to workers in an AMHS compared to a family/carer worker in a MHCSS/NGO or Peak Body.

Other areas of difference to note were between newer and more established workers e.g. *the discipline of Consumer or Family/Carer Perspective* was in the top 6 topics overall but in the top 5 important topics for those newer to the workforce (<12 months - 3yrs); this should be viewed as a priority topic for newer workforce members. Also of note here, is those in the workforce >10 years identified a need for training in *how to advocate for someone or yourself* as a top 5 priority.

Some of the very broad topics are multi-layered, e.g., boundaries may relate to personal boundaries, professional boundaries and also intersects with other topics such as *using your lived experience* and *self-care*. In developing the training, attention should be paid to exploring these broad categories and identifying what the key areas of priority and need are within these headings.

The topics were generated from currently-available training for lived experience workers, the vast majority of whom are mental health consumer LEW. Additionally, according to the desktop audit approximately 50% of training available for LLEW is designed and delivered by mental health consumer LEW whereas approximately 10% of training courses were developed for mental health family/carer LEW, therefore these topics were heavily skewed towards mental health consumer LEW and there were no topics that reflected the unique needs of the mental health family/carer LEW. .

Participants were asked '*What topics do you feel are most important to cover in the first 12 months as a new lived experience worker?* Open-ended responses were themed and grouped into similar categories:

- 98% of responses were related to 'understanding and navigating the system" as a learning priority. These responses included global and local orientation to the MH system and MH services; models of care, such as recovery oriented practice and trauma informed care; navigating the system; legislative frameworks; language used and different roles in the system and how to work with them.
- 48% of responses identified a topic related to "understanding family/carer discipline and different lived experience roles" as a priority. This category included boundaries and 'scope'

of the roles, how the roles differ from clinical and consumer lived experience roles and working as a LE worker in a clinical setting

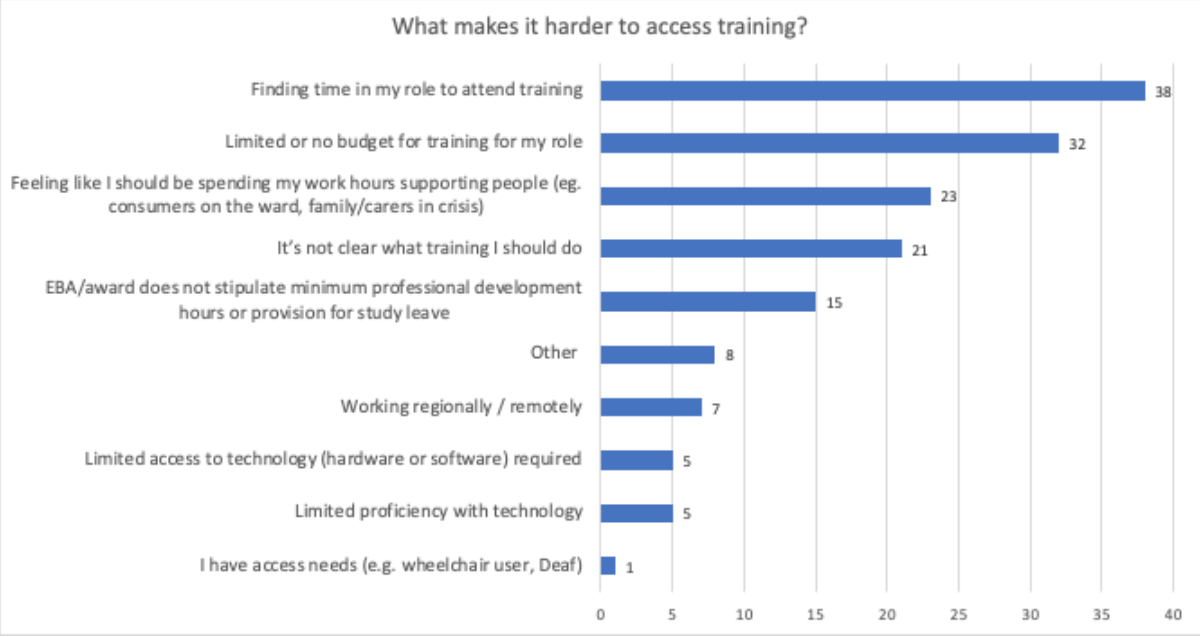
- 46% of responses identified “other skills and knowledge” beneficial to family/carer lived experience work. These were topics that weren’t family/carer lived experience worker-specific but seen as valuable skills such as motivational interviewing, communication skills, IT skills, and how to organise and facilitate meetings.
- 38% of responses related to ‘workplace wellbeing and self care’ including avoiding burnout and vicarious trauma, organisation wellbeing supports, rights and responsibilities with regard to worker wellbeing as well as coping skills and strategies
- 35% of responses related to ‘responding to crisis and complexity’ including balancing dignity of risk and duty of care, suicide, family violence, elder abuse, advocacy skills and conflict resolution.
- 27% of responses related to specific peer support work skills and knowledge including models, tasks and principles of peer support (contextualised for family/carer work).
- 25% of responses related to family/carer workforce skills and knowledge (other than peer support) including general skills for family/carer workforce, understanding and using your family/carer lived experience ethically, holding hope and system advocacy
- 25% of responses related to supervision and practice supports such as discipline-specific supervision, co-reflection, debriefing, networking and mentoring
- 19% of responses related to family centred practice including understanding supports for families and carers, models of family involvement in mental health and aspects of family therapy
- 12% of responses related to family/carer engagement, participation and leadership including engagement strategies, codesign and coproduction

These open-ended responses correlate strongly with the topics identified when participants were asked to select their top 5 topics from the provided list of current topics, however, the responses enabled a better understanding of areas of training need that are specific to the family/carer lived experience workforces such as family centred practice and family/carer workforce skills and knowledge and family/carer engagement, participation and leadership.

Accessibility of training

- **What most helped respondents access to training was**
    - Training offered online (72%)
    - Flexibility of days/hours when the training is held (72%)
    - Allocated budget for training provided by my organisation 65%
    - Enterprise Bargaining Agreement (EBA)/award contains provision for study leave and professional development hours 54%
- Other responses included:
    - Need training relevant to role
    - Testimonials and recommendation from co-workers
    - Transport costs covered
    - Printed materials
    - Paid to attend

- **What made training harder to access**
    - Finding time in my role to attend training 74%
    - Limited or no budget for training in my role 63%
    - Feeling like I should be spending my work hours supporting people 45%
    - It's not clear what training I should do 41%
- Other responses included
    - I've done so much training, it can be repetitive
    - Lack of support from management (3)
    - Training held on days I don't work
    - Constraints of carer responsibilities
    - Lack of relevant training



Further education

Those who responded to the survey are well educated with 63% having an undergraduate or postgraduate degree. Significantly, 58% of respondents indicated they would like to complete further education specifically in LE perspective work.

Of those who said they would like to complete further education in lived experience work:

- 50% would like to do a diploma
- 47% would like to do a masters
- 38% would like to do certificate
- 29% would like to do a degree
- 20% would like to do a PhD

The survey respondents identified a number of barriers to pursuing a qualification:

- cost 31%
- lack of time 31%
- lack of relevant/appropriate further education options 13%
- no recognition of formal qualifications 10%
- age 8%
- work-study-life balance 8%
- caring responsibilities 6%
- lack of support from manager/organisation 6%
- low pay of the role 4%
- travel
- maintaining momentum

Other supports needed

When asked *what, other than training would have been important to support you in your first 12 months* open ended responses were themed into the following groups:

- Supervision, co-reflection and debriefing (18)
    - Importance of regular, discipline-specific supervision or co-reflection. Most responses indicated a preference for independent/external supervision.
- Mentoring and leadership (9)
    - Responses highlighted the value of mentoring by experienced colleagues. Some responses indicated they would like to 'shadow' others in different areas.
- Supportive team (9)
    - Responses indicated the importance of having a team of people in lived experience roles, regularly getting together for check-ins, debriefing and team building days
- Organisation readiness, recognition and valuing of the roles (8)
    - Responses demonstrate the need for greater valuing, understanding and recognition of the family/carer LEW, and being seen as equals to other colleagues.
- Management (6)
    - Responses indicated that managers from the same discipline were highly valued as was regular contact with a manager and clear line management
- Other responses included access to networks (5), orientation to the service/sector (4), role clarity, structure and standards (3) and career progression (2)

Focus Groups

Four focus groups were held. Three with current family/carer lived experience workers and one with current family/carer representatives from two Area Mental Health Services Family/Carer Advisory Groups. 25 people attended, 21 completed a post-group demographic survey.

Demographics

Demographics of the people participating in the focus groups reflected the demographics of the people who participated in the survey.

- 3 people who responded to the demographic survey were under 45 years old, 8 were aged 46- 55 and 10 were over 55
- 1 person is currently employed in a statewide or national service, the remaining 20 currently work in metropolitan Melbourne
- With regard to the highest level of education completed so far:
    - 1 completed secondary school
    - 6 completed a vocational certificate/diploma or advanced diploma
    - 6 have completed an undergraduate degree
    - 8 completed a postgraduate qualification
- In terms of diversity: 4 identified as CALD, 2 as LGBTIQA+ and 1 as living with psychosocial disability
- 19 listed their gender as female and 2 chose not to respond to this question
- In response to *Total time spent working in a lived experience role?* there was a mix of newer and more experienced workers:
    - 5 selected less than 12 months
    - 4 selected 1-3 years
    - 5 selected 3-5 years
    - 7 selected more than five years
- First lived experience role
    - 9 peer support worker (including peer group facilitator),
    - 7 consultant,
    - 4 Consumer or family/carer representative
    - 1 coordinator/manager
- Current roles listed as:
    - 9 consultants
    - 7 peer support workers (including peer group facilitator)
    - 2 coordinator/managers
    - 2 consumer or family/carer representatives
    - 1 selected 'other' and used free text to list three current roles

Focus group questions were the same for the three family/carer workers groups (FCW) but varied slightly for the CAG focus group (CAG) as indicated below:

Question 1

- *What were the most useful topics you learned as a new LE worker? (FCW)*
- *What were the most useful topics you learned to prepare you for representation or participation work? (CAG)*

Question 2

- *What do you wish you'd known in your first year? (FCW)*
- *Beyond your carer experience, what do you think you would need to know to move into employment as a Family/Carer lived experience worker in a mental health service? (CAG)*

Question 3

- *Are there systems/organisational/workplace related topics that would have been useful in your first year? (FCW)*
- *What do you think Family/Carer consultants need to know to support codesign and family/carer participation or representation? (CAG)*

Question 4

- *What training/topics wouldn't you recommend? (FCW)*

Finally both groups were asked *Is there anything that's been missed or you'd like to add?*

Responses were recorded and transcribed, and grouped into themes. Content directly related to training content and needs has been incorporated into the Family/Carer worker Family/Carer Lived Experience Workforce Modules (see section on recommended content, page 33-41 of this report), themes not directly related to training content, but which have a direct impact on training accessibility, knowledge translation and/or the experience of new family/carer workers, have been included below. On some occasions, the authors have added commentary, other times the authors have chosen to allow the voices of the focus group participants to speak for themselves.

Working in an individualistic system

> *Evidence suggests that Victoria's adult mental health system primarily takes an individualistic approach to treatment, care and support without consistently considering the social contexts within which most people live in the community. This individualised approach means that the valuable role families, carers and support networks can play in a consumer's recovery is often overlooked by services, as is the notion that families, carers and supporters have needs in their own right.* (State of Victoria, p 72)

This individualistic approach to mental health treatment, care and support significantly impacts on families and carers and also on family/carer workers. Focus Group participants spoke of the need for all family/carer workers to be advocates for family inclusive practice not only those in system change or advocacy roles.

> *"I had to convince my clinical team that the way peer work was conducted was different to the way the clinicians worked with the client, but I was also part of the clients care team. It took months of working through resistance before peer work was included as part of the clients team."* FCW focus group participant

> *"It was easier for clinicians to adapt to consumer peer than carer peers"*
> FCW focus group participant

Documenting their work with families and carers was another area where the individualistic approach of services directly impacts on family/carer workers. In AMHS, families and carers don't have their own file so family/carer contacts are documented in the consumer file. Family/carer workers are very mindful that what they document can be accessed and viewed by the consumer, the impact on the family/carer's privacy and the potential for harm to family relationships and safety.

> *"putting up those notes is just really stressful, that you are putting that out there and being very careful about what you write in order for that not to have a rebound effect at the other end is fraught and very problematic for me."* FCW focus group participant

Some family/carer peer support workers have KPIs so there is both an organisation imperative to document contacts and a moral imperative to keep documentation brief and unspecific.

Training on clinical documentation doesn't factor in the unique needs and context for lived experience workers in general and family/carer workers specifically.

> *"When we first did the (documentation) training at our service they were expecting us, as carer workers, just to document as we would* [as] *a clinician."* FCW focus group participant

> *"I knew about co-writing but haven't worked that out yet but I do write some notes..be as positive and brief as possible."* FCW focus group participant

The need for effective orientation to the service and the system

There is a need for comprehensive orientation to the mental health system and how these systems intersect and interact with other systems, especially the AOD and disability systems. For family/carer workers in Child and Adolescent Mental Health Services (CAMHS)/Child and Youth Mental Health Services (YMHS), this may also include school and child protection systems; for family/carer workers in aged mental health services, this would also include the aged care system.

It is essential for family/carer workers to understand and make sense of the organisation and relationships in their workplace, and also for family carer workers to be able to support families and carers to navigate the sector to get support for themselves and for the person/people they care for. Understanding the system helps family/carer workers to understand, and have empathy for, the experiences of families and carers whose experiences of, and trajectory through, the system may be very different from their own.

> *"That solid orientation is not there … just all those really basic kind of things that, that welcome you into a service and make you feel like you're on solid ground"*
> FCW focus group participant

> *"There is lots of presumed knowledge - the hospital system is an age old institution, which many nurses/doctors have worked in lifelong, but when you're new to it, it's totally baffling"*
> FCW focus group participant

Lack of effective orientation exacerbates existing power imbalance and impacts on family/carer workers' ability to effectively advocate.

> *"when I go into, say, clinical review, there's 20 clinicians and me. And so I need to understand what's going on. And- and understand their language."* FCW focus group participant

Orientation into the sector also includes understanding commonly used language and acronyms to aid understanding and to be able to both challenge the use of jargon by colleagues and translate the language of the sector for families and carers

> *"So it's like, you've gotta learn the language to operate within the system, but then, when you start talking with families, or with other colleagues, you don't want to be using that same language. So, it's a tension, isn't it?"* Focus group facilitator

"I've worked in a number of professional areas. Education, and, uh, medical science. You know, past life, in hospitals and stuff. And, yeah. And I think what often happens is, people hide behind that language." FCW focus group participant

Focus group participants articulated the need to understand the 'system', including the resources, to support both consumers and families/carers as family/carer workers play a role in helping families/carers to understand and navigate the service system for themselves and to help the person they care about to find resources to support their recovery:

"I think what would have helped my clients a lot would have been, if I had a list of resources that I could refer clients to. I have had to make up my own resources." FCW focus group participant

"Can I just say, with NDIS… it really is a minefield, and I don't think anybody ever is going to become an expert in finding their way around it ... I don't think anyone needs to be an expert if they're going into that carer sort of lived experience role, but to have an understanding that actually NDIS can also cause barriers for people because people do feel, from what I've seen, when they've entered the public health system, I feel like some people are being treated differently because they have not got a plan." CAG focus group participant

Organisation readiness

The organisational culture doesn't support genuine valuing or the embedding of the family/carer workforce or pay attention to the needs of this workforce.

"We're very much an afterthought to line managers. And I think there's a lot of confusion around management and these positions." FCW focus group participant

A number of focus group participants spoke of the need for culture change and training for mental health workers to ensure the workplace is ready for welcoming, supporting and working together with family/carer lived experience workers.

"Something which we've touched on is workplace readiness, and that's something which I think is so important and it's not there everywhere. I'm promoting at the moment sort of, if there are any teams that are going to employ a lived experience worker to have done some training, particularly the (Mental Health Professional Online Development) MHPOD working with a lived experience and being supportive of a lived experience workforce. Just to, you know, to lay the groundwork of them being supportive and inclusive. Because it is, you know, I remember sort of trying to work my way into being involved in meetings with families and the clinicians. Sort of I guess, promoting what I could do in that way. But it was actually having to sort of work my way in. There was no welcoming in to start with which I think we need, you know, that needs to change." FCW focus group participant

"..often you weren't welcomed into those meetings. I still remember my first one. I didn't know where the room was. I arrived a bit late. My phone, which was brand new to me, an old phone but brand new, went off in the middle of the meeting, I didn't know how to turn it off. (laughs) Like, you know, one of the senior people in the meeting turned her back to me when she was talking about something. And, you know, I wasn't introduced, it was the most unwelcoming, horrible experience. And because I'd worked in hospitals in a past life, a long time ago, I kind of understood what I needed to do to get around that. But if I hadn't had that past experience to buffer me a bit, I would've been a bit of a puddly mess, I think, in the corner somewhere." FCW focus group participant

Focus group participants spoke about the ways they intentionally modified their communication style in order to not upset, offend or play into negative stereotypes of families and carers.

> *"Sometimes I have to say, "Sorry, I missed that. Could you say it again for me? Sorry." You know I'm quite accomplished at being my daggy self such that I don't offend people as I speak up".* FCW focus group participant

> *"Would have been useful to know how to challenge with tact."* FCW focus group participant

> *"The power differential ... even now, we're doing models of care and looking at co-design and co-production, and we're naming that power differential. Whoa, that is not something people want to engage with. That's (laughs) such a difficult one."* FCW focus group participant

Insufficient positions and insufficient equivalent-full-time hours (EFT)
A recurring theme in the focus groups was the impact of insufficient numbers of family/carer workers, insufficient variety of roles (with some services only having a family/carer consultant and no family/carer peer support workers) and insufficient EFT as the following quote illustrates:

> *"...these positions are part-time, usually… so there's a really interesting kind of intersect, I think, between being good at networking and being able to be, you know, quite visible, I guess, in a service so that people know the role and know who you are. But being able to manage the timeframe that you're given...often people say, "Oh, you know, the carer consultant should be on that meeting, and on that meeting, and on that meeting" and you know, you got to have capacity to actually do it and, and where do those discussions kind of, happen? How do you learn to push back a bit?"* FCW focus group participant

> *"the first 12 months were a blur and I think mine were two hours, two and a half days a week, and I just really had to forge my own way."* FCW focus group participant

The above participant described how working only 5 hours per week impacted on their decision-making about doing training by explaining the impact that investing time in training had on their annual working hours. Not only is flexible delivery important to ensure that people are able to access the training they require to effectively do their job, their roles must provide sufficient hours that they can both participate in training and meet the inherent requirements of the role.

Role clarity and role promotion
Focus group participants highlighted that their managers and non-family/carer LE colleagues weren't able to support them to understand their role and the difficulty of educating your colleagues about your role at the same time as you are, yourself, learning about the role or, indeed, creating the role.

> *"...the challenge of having to educate people about your role when you're learning your role at the same time and the tension that really causes for people"* FCW focus group participant

> *"I was quite isolated and told that I'll create a role myself within that team."* FCW focus group participant

> *"You kind of just, you just have to find your own way, which was really hard."* FCW focus group participant FCW focus group participant

> *"*[what would have helped was] *A clear position description, what exactly the role was, how the service works, the push back I may have faced, boundary setting with families and colleagues, how to develop the carer peer service"* FCW focus group participant

One participant's experience was different and spoke to the value of having both carer lived experience colleagues and clinical colleagues that could help them maintain the boundaries of their role:

> *"I was a sole peer worker across the service, but I was lucky enough to have a bit of a hand over with the person who was in the role previously, who did a great job. And also the Carer Consultant. I think having that carer lived experience perspective, they really helped me to understand what the work was 'cause I think sometimes, I did clinicalise it and that's what you do fall into that because you're in a clinical setting and being the sole person it was really important to have that point of reference that I could go to the... in my case, the Carer Consultant… And also I was lucky enough to have a very strong clinical go-to personal champion that had a really good understanding of carer peer support. And she would be quite strong with me about, "No, you- you know, this is out of your scope." And I needed that. Perhaps... when you're, sort of, over-caring and you know as a carer, we come in and we want to support and care for people. But you know, there's boundaries. It's not that easy to step back and think, "Oh, no this is not part of my role… it needs to go back to the clinical team."* FCW focus group participant

Tokenistic and diffuse lived experience manager roles

Focus group participants spoke of the need for lived experience managers with clearly defined responsibilities and decision-making authority.

> *"So we have a fairly new role… the Lived Experience Coordinator position, but it doesn't hold any, anything really, kind of sits off to the side and it's very unclear as to what that position is meant to do in relation to your line manager who is often a service manager with many, many other responsibilities."* FCW focus group participant

There are limited numbers of lived experience managers or coordinators in services and, where there are these positions, they tend to be roles that are not designated as either consumer or family/carer meaning that family/carer workers could be reporting to, or seeking guidance from, a manager that works from a consumer perspective (or vice versa). Focus group members spoke of the struggle that family/carer workers have in reporting to managers who don't have a sound understanding of family/carer perspectives or work. There is a need for family/carer leadership and management positions.

Power and 'finding your voice'

A common theme in the focus groups was learning how to value your own experience and expertise, especially difficult when your discipline is poorly understood and undervalued by others.

> *"What I have to unlearn is that my value isn't small. My value is actually really important, and it is equal with everybody else. I think that's what I had to unlearn: that I wasn't just a cog in a wheel. I was an equal, an equal party in this team. And I needed to amplify my voice, because I've learnt that, and stand up for myself in ways that I probably- you know, I'm a bit shy about doing that. But, as I find my feet in this, I've been, I find, I'm growing, and I'm speaking up more."* FCW focus group participant

Coproduction and codesign

In both the FCW and CAG focus groups, coproduction and codesign were seen as essential in helping address power imbalances and amplifying disadvantaged or marginalised voices, however it was the CAG focus group participants who had the most to say about the potential and the challenge of coproduction.

Recovery colleges utilise codesign to create courses that are open to consumers, families/carers and clinicians to learn together. The power of this approach in building capability and confidence in people with lived experience is illustrated in the following quote:

> *"I had a wonderful learning experience that recovery college that really made me take off. I did so well at it. And then the carers could come along too with their son or daughter or husband or whatever, and I got up to the stage where I was talking to university students about codesign and stuff like that."* CAG focus group participant

One focus group participant spoke of the need for families and carers to be supported to develop skills in leading codesign.

> *"... is all very well for the Royal Commission to say "codesign, it's got to happen". But to make it happen, there's a whole skilling up of the whole sector, professionals and us and this today...it shouldn't be a once off, really, it needs to be a developmental thing, because co design is going to happen, and who's going to implement it?... Like, if we don't, if we don't get in on the act, it'll be done for us or done to us?"* CAG focus group participant

Family/carer Consultants have an important role to play in facilitating codesign with families/carers in services, however they require both training and support in order for codesign mindsets and skills to be fully realised.

Mandatory training

CMHL consultations with mental health workers around Victoria found that, in some organisations, annual mandatory training requirements are onerous and a barrier to staff completing professional development. This is particularly a concern for family/carer lived experience workers who are often employed in positions with very low EFT. In addition, participants in the focus groups highlighted that the mandatory training required by their organisation was not tailored or appropriate to their role.

> *"*[We are] *required to do the mandatory training that clinical staff need to do ... no consideration given to our context."* FCW focus group participant

> *"We have (aggression management) training, which is the code grey kind of training that everyone has to do. And certainly when I did it, there was a big discussion, actually. Because the lived experience workforce was just starting to grow, and there was actually a big discussion about how this training could be made to be more responsive to particularly consumer lived experience in the room. So, for instance, part of the training is that you learn how to do... I want to say a takedown, but I don't know if that's the correct wording for it. But, that obviously, for someone who might've had an experience of that themselves... yeah. So there's a lot of discussion around that, at the time. And interestingly, I've not been required to do that training since."* FCW focus group participant

Support to enter the workforce

CAG focus group participants spoke of the need for support and training to help them enter the workforce.

"How relevant do you think it is or do you think it's a barrier if somebody wants to go into the lived experience worker role that they need to be tech savvy? Because I think it's actually a barrier for some people too. So maybe if there was some training around that for people that have not necessarily used computers before." CAG focus group participant

Mentoring, networks and communities of practice

Focus group participants spoke of the value of the CLEW as well as mentoring by more experienced colleagues and connection with other family/carer workers in their service in providing support and guidance, boosting confidence and reducing isolation.

"Yeah, it is sometimes that, isn't it? It's just knowing that you've got a handful of people that you can go directly to for that support. And sometimes I'll, you know, I'll have a go myself anyway. But also acknowledging that you don't need to be an expert at everything to still be able to contribute in a valuable way." CAG focus group participant

What is notably different for the family/carer workforce compared to other lived experience workforces is that the CLEW network has provided assistance and connection for new and experienced family/carer workers for around 20 years. Participants in the focus group spoke about the role the CLEW provided in reducing isolation, providing support and connection with mentors, networking, information-sharing and skill and knowledge development especially through the annual two-day CLEW forum. Focus group members powerfully shared about the sense of community, connection and belonging that came when they finally found CLEW. Finding CLEW relies heavily on word of mouth as there are no formal mechanisms for new or existing family/carer workers to find out about CLEW. In addition, the work of CLEW has been limited due to the network largely relying on a volunteer organising committee with limited financial support through auspice arrangements with Tandem and secretariat support and event planning from CMHL more recently.

The CLEW has potential to be the most valuable asset for supporting future training development and promotion of training to family/carer workers, provided the network is resourced to do so.

Self care and the impact of the work

The importance of self care in mitigating the potential negative impact of the work was a theme throughout the focus groups as was the obligation of organisations to ensure that workers are supported by organisations being trauma informed and providing flexible work arrangements, reasonable workloads and support to work strategically for maximum benefit.

"It's very, very difficult, you know, you're already grieving. I mean, I know that I felt like I've been grieving most of my life (laughs) with seeing how people have been, sort of, um, falling to bits around you." FCW focus group participant

"The work can impact on you personally….impact on you in your caring role... at times you might need some flexibility." FCW focus group participant

"... it's not even so much a time management skill or boundary, but it's, it's also just the mental capacity to be spread so thinly across so many things... and at, not a wise thing to just say, "Oh, I've got a foot in here and a foot in here and a foot in here." I have to actually be able to make a valid contribution. So I've been able to just, you know, speak to my manager at the moment and say we need to bring this back to basics, you know and make sure that my role is important in what I contribute to so that I'm not spread thinly with that

mental capacity even though the time might be available to do that." FCW focus group participant

Access to discipline-specific supervision

The value of discipline-specific supervision for family/carer workers was a theme throughout the focus groups for family/carer workers as was the challenges in accessing supervision as illustrated by the following exchange between focus group participants:

> *"I had to wait three years to get peer supervision. It changed everything."*
> *(Response from someone in the workforce for 16years) "still no supervision"*
> FCW focus group participants

Need to understand the experiences of other families and carers

Focus group participants articulated the challenge of lived experience being deeply personal and yet needing to understand and connect with people who may have very different caring experiences.

> *"We come into Lived Experience roles, which are so unique to ourselves and our own experience and, and yet, we're expected to relate to everyone's experience and, and be able to support people in whatever space they're at. And, and that takes a lot of skill, you know, a lot of learning."* FCW focus group participant

In the absence of training about consumer and family/carer lived experiences written by, and for, people with lived experience, generic and accessible courses such as Mental Health First Aid enabled participants to increase their understanding of the experiences of consumers (albeit through a biomedical lens) and then extrapolate this knowledge to intuit how this may be experienced by families/carers as illustrated in the following:

> *"*[Mental Health First Aid] *was the only training that was offered to other clinicians and I just popped in 'cause I wanted to go into it. I learnt heaps of things I didn't know about mental health, and I was working for a clinic and I was the only peer worker, so I had no idea what I was doing. So it really sort of helped me understand what some carers were going through that I just didn't know anything about."* FCW focus group participant

Educating families and carers about how to support recovery

Family/carer peer support workers in particular have a role to play in sharing with families and carers how to support consumer recovery whilst also ensuring their own needs (and those of others in the family) are being met. In recent literature this is referred to as 'relational recovery' (Wyder, Jonas, Barratt and Bland 2021, Wyder and Bland, 2014).

> *"I did the training to be a Mental Health First Aid trainer. And I went into it because I wanted to help, I guess, the community become more, more aware of mental health issues and how to be supportive. But the service I work for just decided that I would deliver it to carers. And I wasn't really sure how beneficial it would be for carers because, you know, we know a fair bit about mental health and how to be supportive. But in doing that training with carers, I found it very beneficial. And some of the learnings gained by some carers, I really felt it was worthwhile. There was one particular carer whom I knew fairly well from support groups, whose attitude was not understanding of what it was like for the person she cared for. And after doing the training, I heard her talking to some other carers saying how beneficial, and you know, saying "do the Mental Health First Aid course", because now she understood what it was like for the person she cared for and was more understanding of how to be supportive*

and not as angry at the person, being more angry at the illness and, you know, sort of being more helpful." FCW focus group participant

There is a need for family/carer workers working directly with families to have training about families/carers' experiences and how to help others to support recovery. This is currently a gap which family/carer workers highlight is imperfectly filled by courses such as Intentional Peer Support, Mental Health First Aid and ASIST. These courses focus on supporting consumers, particularly when they are experiencing a crisis, which may be useful for responding to family members who are in crisis themselves, but not for training family/carer workers in how to support someone caring for a person in crisis.

Focus group participants were very resourceful in finding something beneficial even in training that was less than ideal:

"I sit through training, even parts that I find really unhelpful, it's still useful to be in that training just to get other people's persp...Look, I'm of the attitude any training that I had the opportunity to do, I would do because we always gain something. Do you know what I mean?" FCW focus group participant

"I remember doing the dual diagnosis component of my course. For so much of it, I was just like, "Oh, God. This is terrible." Like, "Why are we learning this?" But, it was actually still really useful, because what it helped, really, was for me to understand what other people are learning, without having lived experience, and their mind frame. And so, just gave me a little bit more, what's the word... Not empathy. Do you know the word I'm looking for? Like, it just- it kind of helped me to understand their perspective, and to not get too frustrated when, you know, if I have a difference of opinion, or if my lived experience is different, it's like, "Well, this is what you've learnt. And I understand how you're coming to that, and your conclusion of things, because, you know, that's what you've learnt." FCW focus group participant

Whilst this demonstrates the capacity of family/carer workers to reflect in order to reframe and find strengths in all situations, this process requires significant mental and emotional effort to extract the learning.

In the following example, a family/carer worker discusses how a skill learned in narrative therapy training was really helpful in making sense of her own situation but needing to be wary of not applying this clinical approach in her work with families and carers.

"I also found an understanding of narrative therapy really, really useful in understanding my own family and my own situation, and useful in understanding how to 'thicken a narrative' or to be aware of not thickening a narrative when talking to carers" FCW focus group participant

These examples all demonstrate the need for training designed by and for family/carer workers in how to support families and carers to support relational recovery within the scope of their role and discipline.

Using your lived experience as a family/carer worker

The importance of training on using your lived experience was a common theme in the focus groups.

"I actually did a, it was like a very brief, um, probably one or two hour session with our service and it was for the whole service. But what I really liked about it, it was going to storytelling and it was about how you would tell your story, you know? As, as, um, for

consumers and carers coming in now. Because it was org wide, it was more about consumers coming in. What I liked about though it actually gave you some boundaries or things to consider when you're telling a story. Now, I think that would be a great basis to use. But to actually really apply it to our space, I think a lot more depth would need to go into that, because I think it's not just if I get up and tell my story in front of a meeting, but how I work that into my individual interactions with carers as well." FCW focus group participant

While this is a common element of any training designed for lived experience workers, and one of the units of competence in the Certificate IV Mental Health Peer Work, there are additional considerations and complexities for family/carer workers. Utilising your story may involve disclosure of information about the person or people that you care for which raises ethical and legal considerations. Family/carer workers need to understand these complexities in order to be able to use self-disclosure ethically and respectfully.

Working alongside, but differently to Consumer LLEW roles

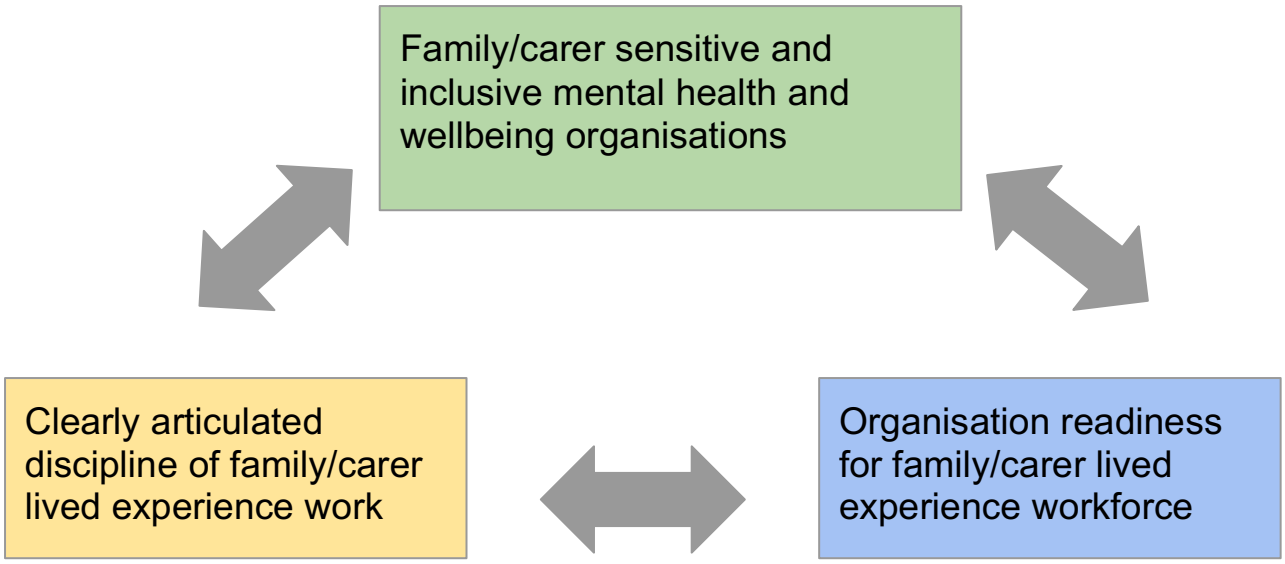
A number of focus group participants highlighted the value of working alongside, and with, consumer lived experience workers in parallel roles (e.g. consumer and family carer consultants working together and consumer and family/carer peer support workers working together). Focus group participants and CLEW Advisory group members both expressed the need to understand how and where the roles and perspectives are aligned, how they might work together for maximum impact, how the roles and perspectives differ and the limits of working together.

"I noticed that- almost no guidelines about articulating the differences between our roles. So, say, carer consultant and consumer consultant. We have some great relationships we've built there. But it's been on working together on the things that are similar. And, similarly, with carer peer support roles, what are the differences between the roles, and how can we augment each other by being articulate about those differences? I think those things often go missing in the need to find allies, and the need to work together, because you know, we've only got each other, sort of thing. So I think articulating the differences would be really useful work we could all do." FCW focus group participant

Discussion

There was a lot of consistency between the messages in the survey and focus groups. This may be due to focus group participants also having completed the survey, however the Advisory Group members confirm the findings from both survey and focus groups are consistent with messages that have been raised to the CLEW and to Tandem.

The survey, focus groups and the Advisory Group all highlight there are urgent and important underpinning foundations that need to be in place for any entry-level training for the family/carer workforce to be successful. Some of these are not unique to the family/carer lived experience workforce, however three that are either unique to family/carer workers or where there are important differences and distinctions for family carer workers are:



These foundations are interrelated and interdependent and are crucial for the ongoing success and growth of family/carer lived experience roles.

Family/carer sensitive and family inclusive mental health and wellbeing organisations

For family/carer workers, this workplace readiness means that services see the value of taking a holistic, whole of family, approach to mental health recovery and are willing and able to be responsive to the needs of families. This includes, but is not limited to, understanding the policy and legislative drivers for working with families, having a deep understanding of privacy and confidentiality legislation, providing support that's oriented around the needs of families and carers rather than the service (such as the ability to meet with families after-hours), and ensuring workers have access to appropriate family-friendly spaces, resources and technology to engage with families and carers.

AMHSs need processes and protocols for documenting family/carer contacts that respect the privacy and safety of consumers and families/carers. Documentation in line with legislative requirements and family/carer needs is a topic that is raised regularly by family/carer workers but will not easily be resolved until services recognise their responsibilities with regard to families and carers. This is an essential foundation for documentation training for family/carer workers.

Advocacy was clearly identified in both the survey results and the focus groups as being a central element of family/carer work. Additionally it was identified as being important both to new and more experienced family/carer workers. Advocacy was broadly defined within both a systemic and individual context and development of training would need to incorporate the complexity of this topic across a number of training priorities.

> *"Some targeted training around systemic and individual advocacy and what that looks like to a service complaints/ feedback/ compliments processes and pathways."* FCW focus group participant

Family/carer worker allies within organisations were identified as highly valuable in understanding how to work effectively in the system, address power imbalances and establish collaborative relationships with other mental health professionals. Organisations have a clear role in proactively

supporting and elevating family/carer workers in developing skills in identifying and building individual and team relationships however family/carer workforce advocacy efforts will continue to be limited by the extent to which the organisation is prepared to work with people in a consumers' support network and, in turn, this will have an impact on the morale of family/carer workers.

Organisation readiness for family/carer lived experience workforce

Focus group participants spoke of feeling unwelcome and the workplace as feeling hostile. They shared feelings of powerlessness, not having a voice and not being heard. Participants articulated the challenge of being responsible for bringing family/carer perspective whilst having to be careful to 'challenge with tact' so as not to be excluded from the conversation the next time. This is where organisation readiness for family-inclusiveness and organisation readiness to employ family/carer workers intersect. Without the former, family/carer workers are likely to be silenced or excluded and services are highly unlikely to ever be ready to employ, support and grow a family/carer lived experience workforce.

The lack of effective and consistent orientation to the sector, service and their role as well as challenges with accessing discipline-specific supports (such as supervision, mentoring and debriefing) were all experienced as examples of lack of organisational willingness and preparedness to employ and support the family/carer lived experience workforce and family/carer lived experience work being viewed as lacking importance and value.

Family/carer workers spoke of the significance of having a team of people in family/carer lived experience roles who are able to regularly get together for check-ins, debriefing and team building. Managers from the same discipline were highly valued as was regular contact with their manager and one clear line of management to report to.

Both focus group and survey participants highlighted the value of informal, on the job training and mentoring from experienced colleagues with some indicating they would like to shadow others in different areas.

Responses from the survey, and particularly the focus groups, highlighted the critical importance of workplace readiness to employ family/carer workers which involves the following components:

- Readiness and willingness as well as capacity for change. CMHL have developed an organisation readiness framework including toolkit and other resources which, unlike other organisation readiness tools, has been codesigned with both consumer and family/carer lived experience workers.
- Providing a sufficient number and variety of positions at appropriate EFT to respond to the needs of families and carers. This has also been identified as a priority in the *Strategy for the Family Carer Mental Health Workforce in Victoria* (Lived Experience Workforce Strategies Stewardship Group, 2019).
- Organisations have succession and growth plans for the family/carer lived experience workforce. Families and carers are supported and trained to maximise the value of their involvement (for them and the organisation) in coproduction, codesign, engagement and participation activities as well as provide pathways to employment.
- State-wide and local support structures for family/carer workers within and across organisations including designated family/carer lived experience manager/coordinator roles, discipline seniors, mentoring, networks and communities of practice, access to paid (ideally

external independent) discipline-specific supervision. These structures are essential for support, knowledge translation and help with problem-solving and contingency planning.

- Mandatory training for family/carer lived experience workers is contextualised to the needs of family/carer workers. Family carer workers are not required to participate in training that does not support their work.
- All staff in mental health and wellbeing services understand and recognise the family/carer lived experience workforce as having a role and expertise that is different but of equal value to that of other colleagues.
- Prioritising and supporting family/carer workers' professional development and career progression.

Clearly articulated discipline of family/carer lived experience work

Just as this project found a lack of literature about training for family/carer lived experience work, there is a lack of information about the family/carer lived experience discipline in the published and grey literature. Much of what is written about lived experience work draws heavily on the literature and experiences of the consumer workforce which then masks the uniqueness of family/carer lived experience work. There is a need for investment in research into family/carer lived experience work to address this disparity and support the integrity of family/carer and consumer lived experience work. There are currently two family-carer led research projects being conducted about the family/carer lived experience workforce in Victoria:

- The Carer/family Lived Experience Workforce Study investigating the *roles, activities, responsibilities and practices* of those in family/carer lived experience positions. This project is led by Peter McKenzie at LaTrobe University
- The Rising Together Study investigating the *experiences* of family/carer workers in mental health services. This is a co-produced research project led by Kath Sellick at the University of Melbourne. This study is due to be completed June 2022.

Both these studies will be instrumental in illustrating the work and experiences of family/carer workers in Victoria when they are completed in 2022, however, it is the experience of both these projects that there is much that lies outside of their scope.

The *History of lived experience work in Victoria (CMHL, 2019)* explains how lived experience positions grew organically in mental health services in Victoria. This organic growth, coupled with a lack of clear organisational understanding of the purpose and activities of the various roles and the recent, rapid expansion of family/carer peer support roles, has contributed to role confusion. Family/Carer Consultant roles in particular vary widely across services. Therefore, there is a need to differentiate the work undertaken by family/carer lived experience workers in their roles.

The *Strategy for the Family Carer Mental Health Workforce in Victoria* (Lived Experience Workforce Strategies Stewardship Group, 2019) recognised the impact of this role confusion and the literature gap and the following objectives and actions were identified:

1 DEFINING – the discipline and roles

OBJECTIVES	ACTIONS	PROPOSED TIMEFRAME
1.1 Family carer work is recognised as a discipline, with several specialisations within the discipline (e.g. peer support worker, consultant, advocate etc.).	1.1.1 Clarify principles and practice of family carer work and specialisations: • Undertake literature review on family carer work • Research current practices in Victoria, Australia, internationally	Immediate
1.2 Principles of family carer work are identified and adopted.	1.2.1 Develop principles, tasks and ethics related to family carer work and specialisations.	Immediate
1.3 Roles, responsibilities and expectations are clearly defined and consistent across organisations, while taking into account local needs.	1.3.1 Develop template position descriptions listing core principles, practices, responsibilities, knowledge, skills and experience required for the position	Medium
1.4 Family carer work is based on a clear understanding of the needs of families and carers – grounded in research and real-life experiences of families and carers.	1.4.1 Gather and translate evidence into practice through training and development resources.	Medium
	1.4.2 Create a knowledge bank or library of evidence based on family carer perspectives.	Medium

(Lived Experience Workforce Strategies Stewardship Group, 2019 p8)

Although this work was highlighted as immediate (complete within 12 months) and medium term (complete within 3 years), more than two years on only 1.2 has been completed. This work will provide a crucial foundation for the development of any training for family/carer lived experience workers, however considerable investment is required to coordinate and facilitate this work.

Survey and focus group participants identified boundaries, role clarity and role drift as essential training topics to be covered in the first 12 months. Boundaries, in particular, is a broad topic and it's unclear whether participants were referring to professional boundaries, personal boundaries or role scope and limitations. The difference between clinical and consumer work boundaries is explored in detail in IPS training, however, appropriate boundaries for family/carer lived experience workers needs discussion and exploration.

The Advisory Group members raised an additional consideration to be explored which is whether a family/carer worker's relationship to the person or people they care for (e.g. partner, parent, child, sibling, grandparent etc.) influences the way they work. Advisory Group members identify that they find it easier to connect with, support and advocate for families/carers in similar relationships to

their own. Caring With explores the needs of different carer groups and this has been experienced as a valuable conversation as participants can share similarities and differences from their own stories. However, this is an area that would benefit from research and investment.

Training development, accessibility, delivery and content

Family/carer workforce training needs to be family/carer workforce led

Intentional Peer Support (IPS) is to date the most accessible course for family/carer workers due to the Department of Health funding positions in this course from 2016 to current. Initially, this training was made available through the Expanding Post Discharge Peer support Initiative but was later offered to all family/carer lived experience workers. Focus group and survey respondents indicated that there are aspects of the IPS 5-day core skills course that are relevant *for peer support workers*, especially the tasks and principles and clarity around what peer support is and isn't. However both survey and focus group participants have highlighted that, although the tasks and principles of IPS are helpful, as is a greater understanding of consumer experiences, needs and perspectives, there are limitations in the effectiveness of IPS training for family/carer workers in its current format due to the lack of contextualisation for family/carer workers and complete absence of focus on the experiences and needs of families and carers, as illustrated in the following quotes:

> *"I am going to be super controversial but I found IPS quite difficult, I do agree with the principles, but the whole week was very taxing and I didn't feel entirely safe throughout the training."* Focus group participant
>
> *"As it was heavy with consumers, I felt like I was back in my caring head space."* Focus group participant

Additionally, IPS training does not meet the needs of family/carer lived experience workers who are working in system advocacy/change or policy roles, rather than peer support roles.

Credibility and relevance will be critical to the success of any entry-level training program for family/carer workers. Some participants in the focus groups did not participate in IPS training as they were told by other family/carer workers that the training wasn't relevant to them. Therefore, to ensure training for family/carer workers is attractive, appropriate and attuned to the needs of family/carer workers and has credibility with family/carer workers, it is essential that any training be developed by, and with, the family/carer workforce.

Caring With: Orientation to Family/Carer Lived Experience Work (CW) and Single Session Peer Work (SSPW) have both been developed by, and with, family/carer workers and, together, the content of both these training programs cover some of the training content that has been identified by the workforce. CW in particular was developed with both direct support (peer support) and indirect support (consultant or policy) positions in mind. Although SSPW is focused on using a single-session framework as a family/carer peer support worker, there is potential to utilise a single-session framework in conducting engagement and participation activities with families and carers. There is potential to build on CW and SSPW courses as foundational training for the family/carer lived experience workforce.

SSPW is often confused and conflated with Single Session Family Consultation (SSFC) which is a solution-focused, brief intervention model for family-inclusive practice designed for clinicians to bring greater family/carer involvement into their work with consumers. SSFC is therefore of limited

relevance to family/carer workers working directly with families and carers. This confusion means that some work is required for SSPW to articulate it's unique identity and target audience.

It is therefore recommended that the 'Caring With' training be reviewed, evaluated and expanded to incorporate the core training needs of the family/carer workforce with additional specialty modules to suit the needs of those areas identified.

Training accessibility

Currently, according to the Our Future survey, 30% of family/carer workers received no training in their first 12 months of employment. Further, there are challenges for family/carer workers finding and accessing training as there is very little that is highly relevant. There was a consistent theme in both the survey and focus group responses that family/carer workers did not know what training to do as nothing felt like the right fit and that there were mixed messages from colleagues and managers about the relevance of what little training there is available.

> *"I would've appreciated a list like this to choose from. The training I did was great, but not very orienting around peer work."* Survey participant

To ensure accessibility, training will need to be held online with flexibility in delivery especially as there is a high likelihood that this workforce (96% women and 88% over 35 years old) have current caring responsibilities for children and/or elderly parents as well as their mental health caring role. Training needs to be tailored to the low EFT of the workforce and allow for flexibility in enabling access and engagement in training for a workforce that is older, educated and multitasking across their community, home and workforce responsibilities.

Self-paced learning allows for maximum flexibility, however high quality self-paced online learning is expensive to produce and there are a number of limitations, particularly for a highly isolated and emerging workforce. Therefore a mix of self-paced online learning and real time face-to-face online or blended online and face-to-face training would give the most flexibility while also reaping the benefits of real-time connection with trainers and peers. Prior to COVID, online delivery was far less accessible due to people's lack of access to technology and lack of confidence and proficiency with using online platforms to communicate, however, COVID has seen a rapid uptake in use of technology such as video conferencing. Care should be taken to ensure that online delivery does not prevent accessibility for anyone in the workforce.

Participants in the focus group and survey indicated that their roles are under much pressure and they feel compelled to support people rather than indulge in further education and training. Participants highlighted structural supports that are required to ensure training is accessible for family/carer workers such as:

- an allocated training budget, including travel expenses for regional/rural workers
- provision for study leave in the award/EBA
- backfilling of hours ensuring that training is able to be completed in work time without creating further burden on already low EFT

The CLEW Advisory Group members are aware that regional/rural family/carer workers are much more isolated than many of their metropolitan peers due to low numbers of family/carer workers (sometimes they are the sole family/carer worker). Additionally, rural services are less likely to have

any family/carer peer support workers which means that sole family/carer consultants are often performing direct peer support, engagement and participation activities, policy review and other systemic advocacy work across large geographic regions with low EFT. Therefore, there is a need to do further research to understand the unique needs of regional workers.

Pathways to further education

Despite coming third behind cost and lack of time, in reality, the biggest barrier to further education in lived experience perspective work is the lack of any relevant options. Queen Margaret University in Edinburgh is offering the world's first Master's degree in Mad Studies, a field of scholarship focused on the lived experiences and social context of people identifying as mentally ill, however there is no equivalent qualification for family/carer workers.

At present, options for career progression are very limited due to limited numbers of family/carer leadership roles. Therefore family/carer workers who wish to increase their earning capacity and have career options in mental health have little choice but to retrain and transition into other roles in mental health such as social work, nursing or occupational therapy. However, considering the age demographics and the challenges of cost, time and juggling work, caring and community responsibilities, this option is only really accessible to those with considerable financial and practical support.

Training Content

In addition to the high number of people who received no training in the first 12 months, there are concerning gaps in training highlighted by participants in both the survey and focus group discussions. Most notable is the lack of orientation to the sector and to the service the family/carer workers are working in. This means family/carer workers are exerting significant efforts to orientate themselves unless they are lucky enough to meet someone in a lived experience role who is able to mentor and orient them. Feeling 'on the back foot' contributes to an already existing power imbalance.

Although orientating families and carers to the mental health service is arguably a task that should be done by clinicians, it's essential that family/carer workers are able to support families and carers to navigate the system. One focus group participant shared how critically important this is in the context of constant change:

> *"You're trying to develop an idea of trust in the system. And- and that is one of the biggest weaknesses because there's change with policy and change with staffing. There's so many things within the system. You might start out thinking you know the system and then things change again."* CAG focus group participant

Allied health workers in mental health also report the need for orientation into the mental health sector and CMHL have developed and delivered the Statewide Allied Health Entry Level Training Series (based on work previously delivered as part of the NEVIL training cluster) to address this need. This program is a series of 8 distinct 1-day online workshops on subjects such as the mental health service system, legislation, principles underlying the models of care and foundational clinical mental health skills. The target audience is allied health clinicians in their first two years of working in a clinical mental health role. It is possible that Family/carer Workers would find the content of this workshop series useful, however, the training has been developed by and for allied health clinicians

working with consumers so would need to be reviewed and rewritten in order to ensure relevance to family/carer workers.

Training needs to be relevant and safe for family/carer lived experience workers who are in an identified diversity category (23%) to enable access and engagement in training. This group also represents a significant resource as they could contribute much to training other family/carer workers about these diverse experiences and perspectives

There is a need for family/carer workers working directly with families to have training about families/carers experiences and how to respond to their needs.

> *"I was working with many carers who didn't know how to respond to their loved one's suicidality"* survey respondent

This is currently a gap as courses such as MHFA and ASIST focus on the needs of the person in crisis (which may be useful for responding to family members who are in crisis themselves) but not for family/carer workers who are supporting someone caring for a person in crisis. There have been a number of programs developed over the years for peer-to-peer delivery, however, many of these are outdated and/or are no longer being delivered. Wellways *Building a Future* is one of the few Australian examples that is currently still running for families/carers. Others that show some promise are: *Recovering Our Families* is an online program "purposely facilitated by people who have recovered from being labelled with a psychiatric disorder and/or who have family currently in recovery" (familieshealingtogether.com). *Emotional CPR* is a two-day program designed to teach people to assist others through an emotional crisis developed with input from a diverse group of people who have learned how to recover and grow from emotional crises.

Funding is needed to explore the viability of a coproduced program developed by families/carers, family/carer workers and consumers to assist families/carers to learn how they can support relational recovery.

Family/Carer Lived Experience Workforce Modules

All family/carer workers

Understanding family/carer perspectives, experiences and needs

Orientation to the system; mental health, family/carer, disability and AOD

Orientation to family/carer work in mental health services

Workplace wellbeing in mental health services

Facilitating meetings and groups

Direct support roles	System change/ advocacy roles	Leadership roles
Providing direct support to families in mental health services	Working within the system for change	

Delivered over 12 month period
Individual modules

- Core = green
- Electives = purple
- Direct support specialisation = yellow
- System change/advocacy specialisation = blue
- Leadership specialisation = orange

Understanding family/carer perspectives, experiences and needs

Learning outcomes

At the completion of this module learners will be able to:

- Reflect on their own experiences as a family/carer
- Discuss ways in which others' family/carer experiences are similar and different to their own
- Express some of the diversity of family/carer experiences and needs
- Describe the family/carer movement and advocacy messages

- Access family/carer literature

Topics include:

- Language and definitions: carer, nominated persons, family, young carers, consumer
- Impact of discrimination and stigma on families
- Family/carer experiences from the literature e.g. Carer Lifecourse Framework, Relational Recovery, carer grief and loss, emotional side of caring
- Similarities, differences and needs by relationship e.g. siblings, parents, partners, children
- Some of the complexity, use of 'stories' and family experiences to illustrate
- Family dynamics: learnings from lived experience and family systems literature, relationship with consumer(s), changes relationships with all the family members due to caring
- Diversity and intersectionality of families/carers - needs of CALD carers, Aboriginal and Torres Strait Islander, LGBTIQA+ carers,
- Family/carer movement and advocacy messages
- Family/carer rights
- Understanding trauma, intergenerational trauma and families

Orientation to the system - mental health, family/carer, disability and AOD

Learning outcomes

At the completion of this module learners will be able to:

- Describe key elements of the Victorian mental health system, including services, workforce and policy/legal frameworks
- Name key elements of the AOD and disability sectors
- Identify and summarise key messages from policy and legislative frameworks for working with families and carers
- Access and link families/carers with support and information services
- Describe recognised models of supporting families and carers that may be used in mental health services and settings
- Apply different models of understanding 'mental illness' including but not limited to the medical model and trauma informed
- Describe recovery as it relates to consumers and family/carers

Topics include:

- Understanding the Victorian mental health system with family/carer context
    - Understanding what different mental health workforces do (clinical and lived experience workforces)
    - Child/youth services
    - Adult and Aged services
    - Language and jargon used in this sector, common abbreviations
    - Role of peak bodies
    - Family/carer experiences of services; privacy/confidentiality/information sharing & consent issues
- Intro to the AOD system (including AOD and Dual Diagnosis services as well as specialist services)
- Intro to the Disability system: NDIS, dual disability

- Understanding different ways of understanding ‘mental illness’ including but not limited to the medical model and diagnosis, trauma
    - Introduction to trauma informed care
- Introduction to mental health policy and legislative frameworks
    - Mandatory reporting and MARAM
    - Victorian Mental Health Act / MH Tribunal
- Introduction to policy and legislative frameworks for working with families and carers
    - Victoria Carer Strategy 2018-2022
    - Carer Recognition Act
    - OCP guidelines
- Services and resources for families/carers e.g. Carer Gateway, Carer Support Fund, Centrelink financial supports, support groups
- Understanding the possibilities: models of family/carer work in mental health services:
    - Single session family consultation
    - Multiple family groups
    - Open Dialogue
    - Family/carer engagement continuum: from exclusion to coproduction
    - Pyramid of Family Care
    - Clinician led vs peer led and facilitated

Orientation to family/carer work

Learning outcomes

At the completion of this module learners will be able to:

- Summarise the historical influences of the consumer, carer and peer support movements on family/carer lived experience work
- Describe core elements of family/carer lived experience work
- Identify and discuss differences between family/carer lived experience work and other workforces in mental health services
- Identify what is in and out of role scope for family/carer workers and communicate this to others
- Apply their lived experience to connect with families/carers and explore different worldviews
- Illustrate shaping their storytelling for different audiences
- Summarise key elements of a single-session approach to working with families and carers
- Demonstrate core communications skills of family carer lived experience workers
- Identify, describe and demonstrate examples of workplace and personal boundaries
- Promote family/carer lived experience work to different audiences

Topics include

- What is family/carer lived experience work?
    - Values, tasks and principles of LEW
    - Role scope – what’s in and what’s out
    - Similarities and differences in roles across organisations (specialist teams)
    - Power imbalance between peer and clinical staff
    - Difference between having lived experience and working in a LE role
- How does family/carer lived experience work differ from:

    - clinical work
- Consumer work
- Family/carer workforce roles
    - History of the roles in Victoria
    - Introduction to direct/peer support work
    - Introduction to consultant work - system change/advocacy roles
    - How do the roles work together?
    - The strategy for the Family Carer Mental Health Workforce in Victoria (2019)
    - Potential for leading/ involvement in relevant research
- Role clarity challenges: peer drift and being alert to clinicalisation of the role, 'dual roles'
- Making the most of the time you have together: single session framework
- Boundaries and limits as a family/carer worker
    - Power and abuse of power
    - Navigating dual relationships
    - Professional boundaries/limitations
    - Personal boundaries
- Promoting family/carer work: Communication with colleagues and others (including families/carers) about your role
- Purposeful storytelling/disclosure;
    - Reflecting on your own journey and how this shaped you
    - Shaping and telling your stories
    - Limits of self disclosure: 'no go zones', privacy, personal 'hotspots', managing intrusive questions
    - Legal and ethical considerations e.g. others' privacy
    - Preparing to share: 'right time and place'
    - Adjusting your message and story for different audiences
- Core communication skills
    - Active listening, empathy, connection, compassion, worldview, mutuality and rapport, validation, strengths, non-judgemental/non-blaming
    - Assertive communication: understanding your value and 'finding your voice'
    - Difficult conversations: 'challenging with tact' and other conflict resolution skills
    - Information sharing, documentation, and confidentiality
    - Networking skills
- Challenges and ethical dilemmas
    - Working in unwelcoming, unfriendly or hostile environments
    - Responding to distressed and suicidal family members/carers

Facilitating meetings and groups

Learning outcomes

At the completion of this module learners will be able to:

- Identify key elements of successful meetings and groups
- Describe similarities and differences between different types of groups
- Describe principles and mindsets of coproduction and codesign
- Apply lived experience to working with groups
- Plan and facilitate a group relevant to their work role
- Apply single session framework to planning and facilitating meetings

Topics include

- Facilitating workshops
- Facilitating support groups
- Meeting facilitation skills
- Cofacilitation skills
- Cofacilitating with clinicians
- Making the most of the time you have together: single session framework in meetings

Workplace wellbeing

Learning outcomes

At the completion of this module learners will be able to:

- Describe positive impacts of family/carer lived experience work on the worker
- Understand the potential impact of burnout, compassion fatigue and vicarious trauma on family/carer workers
- Explain why self-care is essential for family/carer lived experience workers
- Name and describe how to access personal and workplace resources to support wellbeing
- Identify activities that support their self-care and develop a personal wellbeing plan
- Describe the benefits of family/carer discipline-specific supervision
- Understand and apply knowledge of industrial protections and rights of working carers such as requests for flexible working arrangements
- Understand and describe organisation and personal responsibilities around managing wellbeing in the workplace
- Discuss and compare supports available for family/carer workers in Victoria
- Develop a professional development plan
- Identify models, frameworks and evidence that guide family/carer lived experience work

Topics include:

- Bringing your lived experience to work
- Burnout/compassion fatigue and vicarious trauma
- Self care and wellbeing tools
- Keeping it real - challenging service expectations
- Moral and ethical dilemmas
- Health and Safety in the workplace
- Workplace rights (Unions, reading your EBA or award, EFT, benefits and entitlements, negotiating flexible work arrangements or reasonable accommodations)
- Supports for your role;
    - Holding space for your colleagues - coreflection/debriefing
    - Discipline-specific supervision, how to effectively use supervision
    - CLEW Network
    - EAP
- Honing your skills and improving your practice
    - Career progression

Providing direct support to families in mental health services

Learning outcomes

At the completion of this module learners will be able to:

- Describe values, principles and tasks of family/carer peer support

- Apply their lived experience to connect with and support families and carers
- Utilise single-session framework to co-create a plan for a meeting with a carer to identify and prioritise the family/carer's needs
- Demonstrate mutuality in sharing skills and knowledge with families and carers, demonstrating mutuality and seeing families and carers as capable co-learners and avoiding taking an advising or problem-solving role
- Apply an understanding of their own worldview and demonstrate curiosity and openness in exploring others' worldviews
- Explain sharing of risk and responsibility to families and carers

Topics include:

- History of peer support/self help movement
- Tasks and principles of family/carer peer support work
- Making the most of the time you have together: single session peer support work
- Skills sharing with families/carers
    - Supporting family/carer self-advocacy
    - Supported decision making for families and carers
    - Supporting recovery; consumer and relational recovery, CHIME(D)™
    - Family/carer self care/recovery
    - Supporting dignity of risk
    - Planning ahead - aging carers
    - Safety planning
        - Domains of safety: physical, emotional, financial, psychological and spiritual safety
        - Working together for safety (family/carer and consumer safety)
        - Family violence
        - When and how to escalate
        - Working strategically, prioritisation and time management
- Working with vulnerable and distressed families/carers
- Working as a lived experience worker within the medical model
- Working collaboratively in a multidisciplinary team
    - Working with others to enable family-inclusive practice and supporting relational recovery
- Peer support work in different settings
- Documentation and data
    - Documenting as a family/carer lived experience worker
    - Privacy legislation and documentation of family/carer contacts
    - Collecting and using evidence to improve your practice

Working within organisations for change

Learning outcomes

At the completion of this module learners will be able to:

- Describe key policy and legislative drivers of change with regard to family-inclusive practice
- Explain the role of family/carer workers in mental health services
- Plan and prepare for participation in committees
- Define coproduction and codesign principles and mindsets
- Identify two ways to apply coproduction and codesign principles in their work

- Seek, collate and communicate family/carer experiences of service
- Determine strategic priorities with regard to working with families and carers
- Advocate for embedding family / carer inclusive practice

Topics include:

- Coproduction and codesign
- Mechanisms for enabling family/carer voices to be heard
- Advocating for embedding family / carer inclusive practice
- Educating other mental health staff about working with families and carers
- Documentation and data: collecting and using evidence to drive improvements
- Understanding the mental health policy and legislative frameworks for working with families and carers and how that legislation impacts on working with carers
- Working strategically, prioritisation and time management

Leadership

Topics include:

- What is family/carer leadership?
- Communication skills
- How to support the family/carer workers
- What is family/carer lived experience supervision
- Co-reflection

Recommendations

1. Because of low numbers of regional workforce respondents, there is a need to do further research to understand the unique needs of regional workers. Recommendation to do additional focus groups with rural/regional workers and/or ensure strong representation from regional/rural workers in the coproduction group for the development of the training as well as prototyping with rural/regional workers.
2. While the authors of this section would not support people working in dual lived-experience roles, there is value in exploring how the different perspectives and advocacy messages of both groups inform their work, as well as how having dual lived experience influences lived experience work in either a family/carer or consumer role. Recommendation to fund research into how lived experience as a family/carer, consumer or both influences lived experience work.
3. Caring With and Single Session Peer Support partially, but don't completely meet the needs of family/carer workers in a range of roles and settings. Recommendation that development of entry-level training for family/carer workers involves review and update of Caring With and Single Session Peer Work content and delivery.
4. There is a need for family/carer workers working directly with families (for example Peer Support Workers) to have training about how to support carers to support recovery. This is currently a gap as mental health literacy and suicide prevention courses focus on the needs

of the person in crisis, which may be useful for responding to family members who are in crisis themselves, but not for responding to someone caring for a person in crisis nor helping them to understand how they can best support recovery. There have been a number of programs developed over the years for peer delivery however many of these are out-dated and/or are no longer being delivered. Some that show some promise and are currently being delivered worldwide are:

- Wellways 'Building a Future'- one of the few Australian examples that currently is still running for families/carers.
- Recovering Our Families is an online program delivered by Krista MacKinnon, who has "lived experience of recovering from a bipolar diagnosis".
- Emotional CPR is a two-day program designed to teach people to assist others through an emotional crisis developed with input from a diverse group of people who have learned how to recover and grow from emotional crises.

Recommendation - Funding is needed to explore the viability of a coproduced program developed by families/carers, family/carer workers and consumers to assist families/carers to learn how they can support relational recovery.

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Appendix 7: AOD Family/Carer Consultation Report and Content Outline

Author:

Fiona Anderson, AOD Family LLE Workforces Consultant, SHARC

Partner organisation:

Self Help Addiction Resource Centre

Family Lived & Living Experience (LLE) Worker/Volunteer Survey & Focus Group Analysis

30 SEPTEMBER 2021

Our Future Lived & Living Experience Project Study Data Analysis
Fiona Anderson – AOD Family LLE Workforce Consultant

Contents

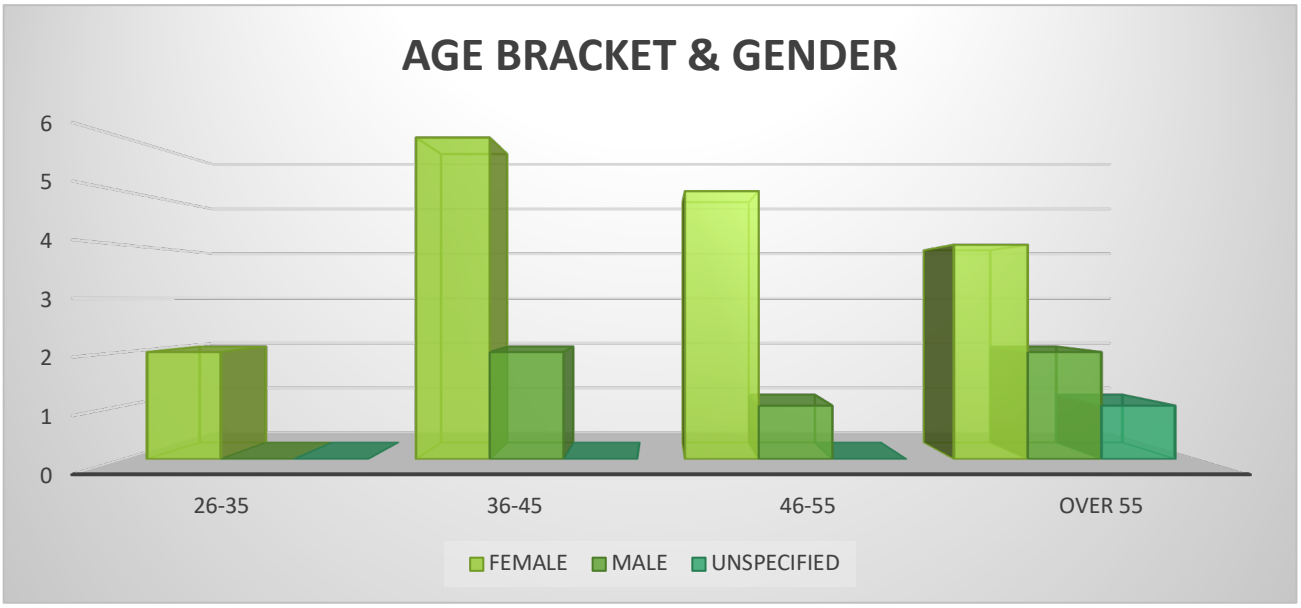
1. Study Limitations

The findings of this study have to be seen in light of some limitations.

- Timeframes for **the p**roject have not been conducive to measured investigation and survey distribution
- Survey findings may not be able to be generalized to a meaningful population, considering N=23, and may not be representative of the general cohort
- The method of sampling may provide an over-representation of a particular set of respondents which cannot, therefore, represent the population as a whole
- Impact limitations of the research may be reduced because of factors of a strong metropolitan focus and being too population-specific
- Implementation of data collection method may be flawed due to lack of extensive experience in primary data collection
- Sampling bias may be present and generalized to persons who are sufficiently interested to complete the survey
- Difficulties engaging with Lived / Living Experience (LLE) Alcohol and other Drug (AOD) Family Workforce given their reticence to consider themselves as being part of a workforce with most of them being voluntary
- Lack of previous studies in the research area of Family LLE AOD Workforce to identify the scope of finding of past research to use as the foundation to be built upon to achieve specific research objectives
- Scope and depth of discussions is compromised on many levels compared to the works of experienced scholars
- Self-reported data from surveys and focus groups is limited by the fact that it is unable to be independently verified and may contain several potential sources of bias which may result in the inability to generalize the research findings such as
    - Selective memory
    - Telescoping
    - Attribution
    - Exaggeration

2. Demographics

2.1 Age Bracket and Gender



There were 23 respondents within the total survey cohort, with 1 person electing not to specify their age. There was an overwhelming response rate from females in all age brackets which may be an indication of the workforce demographics as a whole throughout both Mental Health and Alcohol and Other Drugs Sectors.

2.2 Work Location

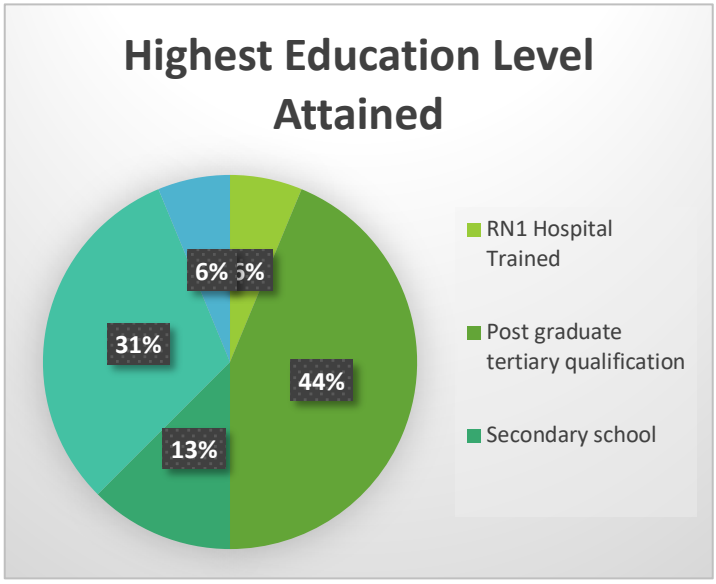
The majority of respondents indicated they currently worked in the Melbourne Metropolitan Region = 21, Regional Victoria =1 and retired =1.

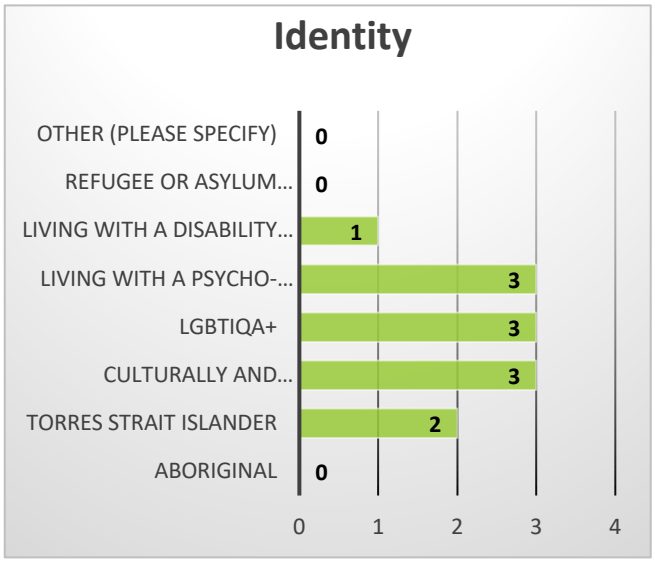
A number of factors could affect this weighted outcome, some of which have been outlined in the list of survey limitations.

2.3 Highest Level of Education

It is of interest to note that most respondents to this question indicated they held a Post Graduate Tertiary Qualification (44%), whilst others held Undergraduate Tertiary Qualifications (31%), VET Diploma/Advanced Diploma (13%), Vet Certificate III or IV (6%) and one respondent had a hospital-based RN1 qualification (6%).

Respondents were not asked to indicate whether their qualification was obtained prior to their commencement as a volunteer or paid member of staff, or after.

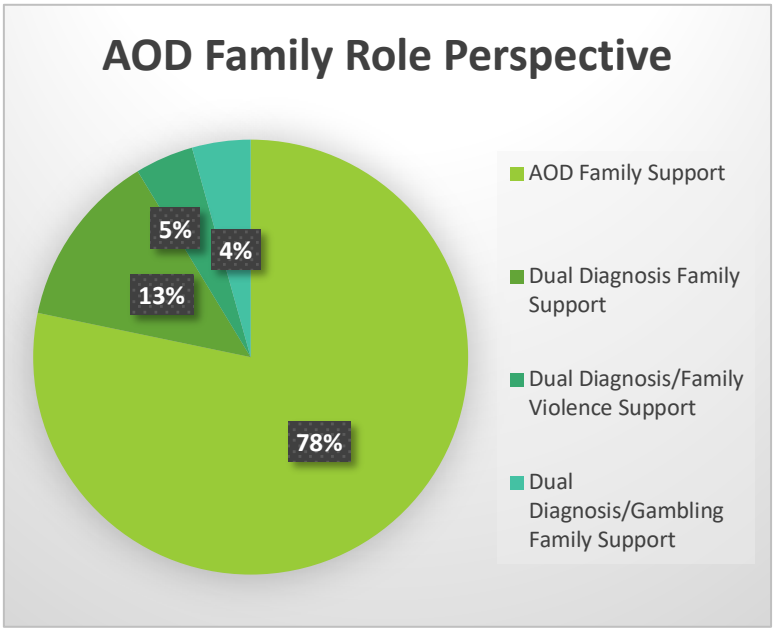




2.4 Identity

No respondent identified as being of Refugee or Asylum Seeker status. 3 people identified as Living with a Psychosocial Disability or CALD or LGTBQI+ identity status, 2 as being of Torres Strait Islander heritage and 1 identifying as living with a disability (other than psychosocial).

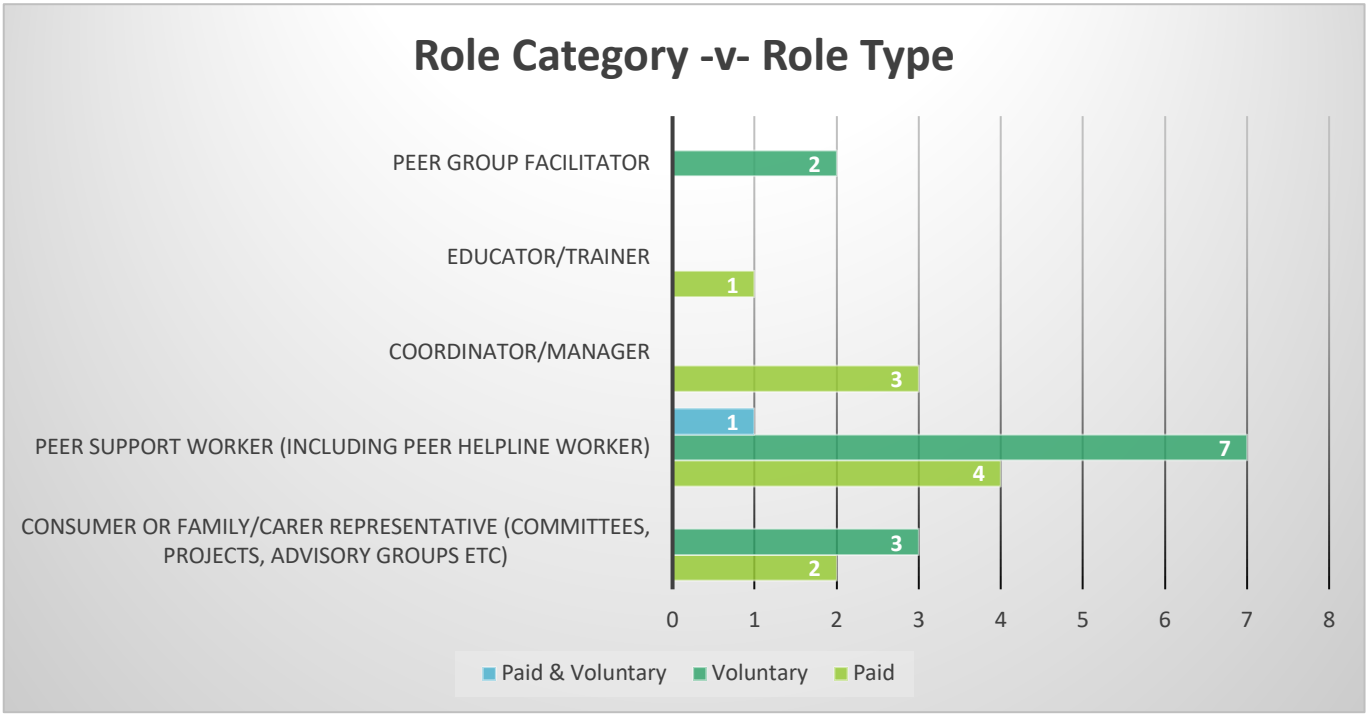
2.5 Role Perspective–- AOD Family Carer/Dual Diagnosis



78% of survey respondents indicated that their role category was LLE AOD Family **Support** Worker, with other categories being LLE **Dual Diagnosis** Family Support (13%), LLE Dual Diagnosis/Family Violence Support (4%) and Dual Diagnosis/Gambling Family Support (5%).

2.6 Role Type -v- Role Category (Paid or Volunteer or Both)

Respondents were asked to indicate the title of their first role as a LLE worker and whether that role was paid or voluntary. Defined roles were provided for selection, with a category of 'Other' made available to cater for all other responses to be detailed.

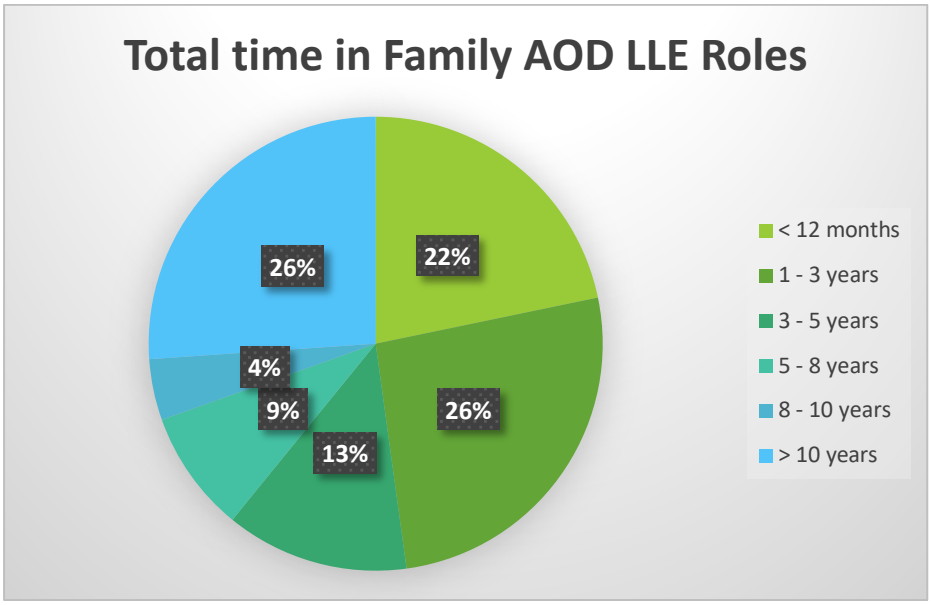


The largest workforce was predominantly the Peer Support Worker role category with 30.49% of the **AOD family/carer** workers completing the survey being in a voluntary role, 17.39% paid and 4.35% having both paid and unpaid components to their role.

A summary of all the AOD LLE Family Workers surveyed: 69.57% were working in a voluntary capacity, 26.09% in paid roles and 4.35% in both categories within the one role.

It is outside the scope of this project to investigate the reasons behind the large proportion of volunteers i**n** the AOD Family LLE Workforce, but the author suggests that there may be a need to obtain further data from a larger LLE AOD Family cohort to substantiate a trend.

2.7 Total Time Spent Working in an AOD Family LLE Role



Overall, there is a considerable amount of experience amongst the LLE AOD Family workers and volunteers surveyed.

It is postulated, that retention rates need broader investigation with a larger cohort to provide more reliable and consistent data and to substantiate any possible trend within the total workforce.

The table below indicates there is a drop-off in the workforce with the largest numbers in the <12 months to 1-3 years and again in the >10 years. This last number could indicate an aging workforce / natural attrition, further supporting the postulation that attraction and retention of highly qualified AOD Family LLE Workers is needed.

Time in Role	Number of Workers	Time in Role	Number of Workers
<12 months	5	5-8 years	2
1-3 years	6	8-10 years	1
3-5 years	3	>10 years	6

3. Training

3.1 Training Undertaken Within the First 12 Months in First Role or Before

Survey respondents were asked to identify any training undertaken within their first 12 months of their first LLE role or before.

Important points in consider in the analysis:

- Respondents were not asked to stipulate whether the training was provided by their organisation or whether they sourced the training themselves.
- It was concerning to note from Focus Group responses, that 100% of participants indicated that training for Family AOD LLE workers was either non-existent or not relevant to their role including both Certificate and Diploma qualification.
- 1 person from the survey indicated that within the first 12 months they did not receive any organisation-provided training, nor did they undertake training or pay for training themselves.
- The survey did not ask respondents to identify whether they had sought and paid for additional training themselves or that the service sourced and paid for it from a designated training budget.
- The incorrect name was initially provided in the survey for the APSU LEAP Training which may be a reason no respondent identified they had done this training

3.2 Training undertaken by the most respondents

Either service-provided, or self-identified and paid for,training courses were:

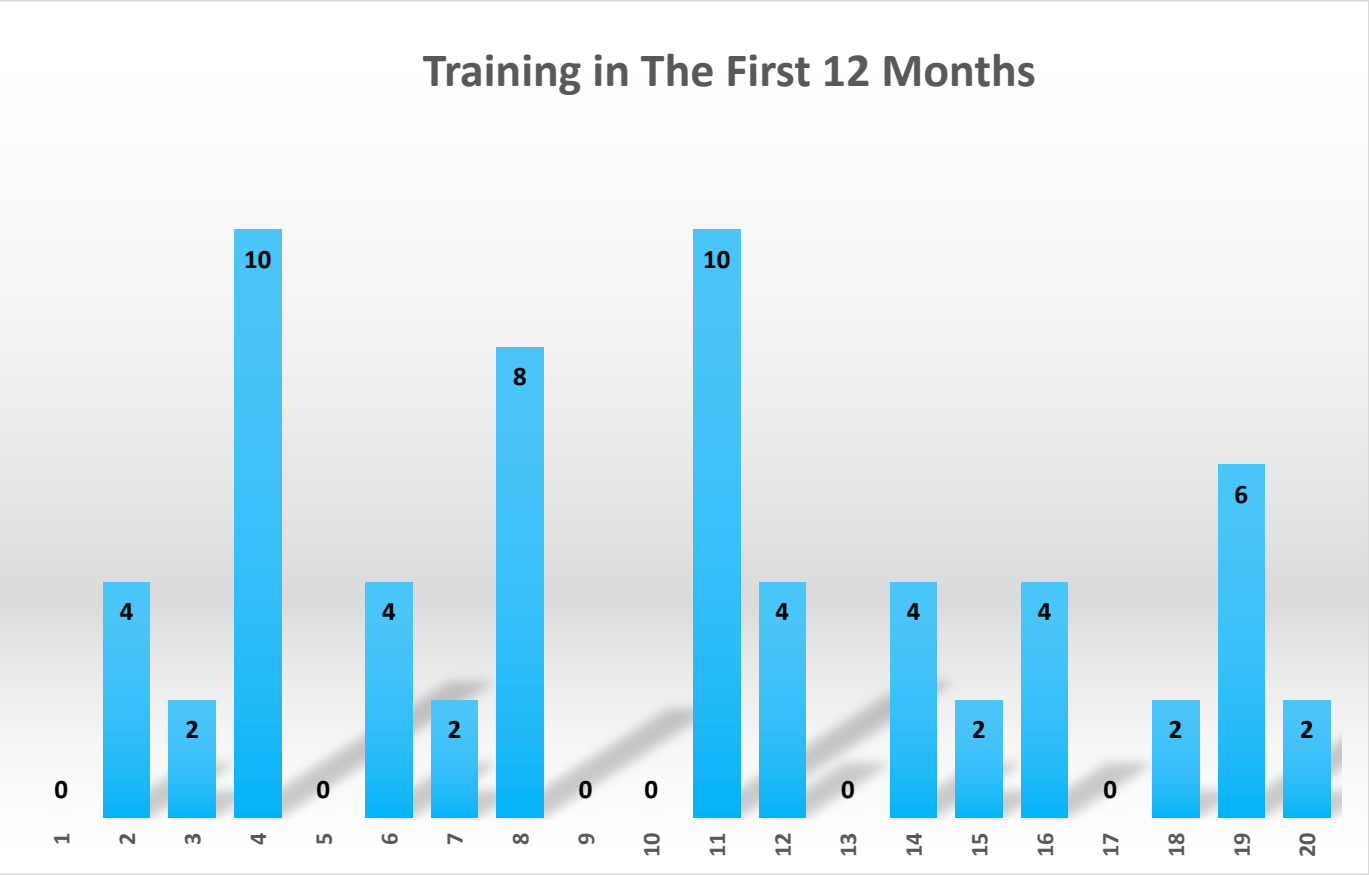
- Intentional Peer Support (IPS) – 10
- Dual Diploma of Mental Health and Alcohol and other Drugs – 8
- Certificate IV in Alcohol and Other Drugs – 10

3.3 Additional Training undertaken by respondents, not represented in the above

- Diploma of Community Services
- SHARC Helpline Training
- Family Drug Support Training
- Psychology Degree
- Social Work

- Informal Mentoring

Some respondents participated in multiple trainings within, or before, their first 12 months in their first AOD Family LLE role indicating a clear desire to seek out appropriate training.



LEGEND INCLUDING PERCENTAGE of COHORT TRAINING COMPLETED in 1ST 12 MONTHS					
No	Training	%	No	Training	%
1	APSU LEAP Training (previously called Peer Helper Training)	0%	2	ASIST training	17.3%
3	Caring With: orientation to carer lived experience work	8.7%	4	Certificate IV in AOD	43.5%
5	Certificate IV in mental health peer work	0%	6	Certificate IV in mental health	17.3%
7	Drug Overdose Peer Education	8.7%	8	Dual diploma mental health and AOD	34.8%
9	Emotional CPR (eCPR)	0%	10	Foundations of Peer Work (Mental Health Victoria/Vicserv)	0%
11	Intentional Peer Support (5-day core skills)	43.5%	12	Mental Health First Aid	17.3%
13	PeerZone training	0%	14	SHARC Peer Worker Training	17.3%

15	SHARC Peer Mentors in Justice Training	8.7%	16	SHARC group facilitation training	17.3%
17	Time for a Change Dual Diagnosis LEW training	0%	18	Training in facilitating peer groups	8.7&
19	Organisation-run introduction to peer work training	26.1%	20	I received no training	8.7%

3.4 Most Helpful & Relevant Training Prior to/Within the First 12 Months

1. The top-rated training was Intentional Peer Support - 21.74%
2. SHARC Peer Worker Training 2nd rated training – 17.39%
3. 13.04% of respondents felt that Training in Facilitation Peer Groups was the third highest rated training along with The Dual Diploma and Mental Health and AOD
4. APSU Leap Training and SHARC Peer Mentors in Justice rated at 8.7% relevant
5. 5 offered trainings that were classified at 4.35%
6. All other training was listed as not at all relevant or helpful or not participated in

Limitation of these findings

The above statistics and the graph do not necessarily indicate that all participants had completed all training. It is limited in findings and clarity around participants having enrolled in and completed/not enrolled and not completed the training.

This can be correlated to Focus Group findings where participants were not aware of relevant and helpful training that was available to them.

NOTE inconsistencies found:

- APSU LEAP Training
  No respondents indicated they had done this training in the first 12 months but this training was noted by 2 respondents as one of the most helpful and relevant (3.4)
- Caring with Orientation to Carer Lived Experience Work
  No respondents indicated that they had undertaken this training in the first 12 months. It was noted by 1 respondent as one of the most helpful & relevant (3.4)
- Emotional CPR (eCPR)
  No respondents indicated that they had undertaken this training in the first 12 months but this training was noted by 1 respondent as one of the most helpful and relevant (3.4)
- Peer Zone Training
  No respondents indicated that they had undertaken this training in the first 12 months but this training was noted by 1 respondent as one of the most helpful and relevant (3.4)
- Time for Change Dual Diagnosis LEW Training
  No respondent indicated they had undertaken this training in first 12 months but it was noted by 1 respondent as one of the most helpful and relevant (3.4)

3.5 Additional Comments Provided on Most Relevant and Helpful Training

There was acknowledgement by respondents of the value of Intentional Peer Support (IPS) in providing them with additional skills and knowledge to support them in their LLE role.

One respondent stated:

> *" I have done IPS at SHARC and it was phenomenal. I had not done this before my first role, but I think it was very important to deliver peer support in an ethical, purposeful way and encourage more reflective practice."*

The majority of those responding to this survey indicated that Family Lived Experience Specific Peer Training was not available to them as an option within Cert III or IV or at a Diploma level. They, therefore, sourced their own training and paid for it themselves.

One respondent's comment is detailed below:

> *"I searched for my own training so to encompass a multi-faceted approach that could be tailored to whatever project or presentation I was doing (IPS, Peer Facilitation, Peer Worker Training, Time for Change LEW Training)"*

3.6 Five (5) Most Important Topics for new Family AOD LLE Workers/Volunteers

From a list of 18 topics, survey respondents were asked to provide their top 5 recommendations for inclusion for training for new LLE workers.

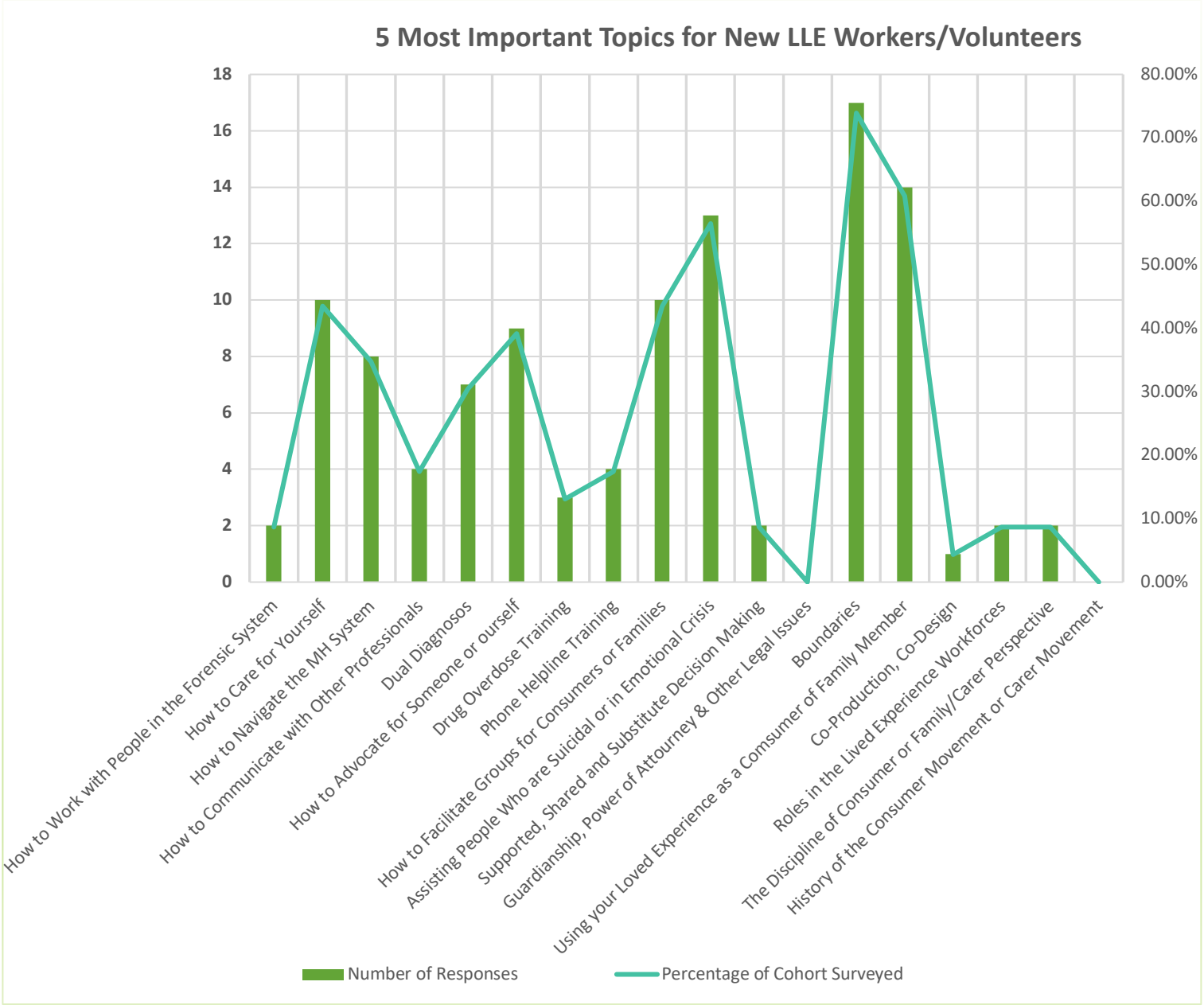
The graph below indicates how people ranked topics with the benefit of hindsight from a number of years of working/volunteering in the sector.

5 Highest Training Recommendations	Less Important Training
• Setting boundaries	• Co-production & co-design
• Using LLE as Consumer or Family Carer	• History of the consumer movement
• Assisting people who are suicidal or in crisis	• Guardianship, Power of Attorney & Other Legal Matters
• Caring for yourself	
• Navigating MH & AOD sectors	

The table above is a summary of the 5 highest recommendations shown in the graph, as well as those that were seen as less important to Family LLE Workers/Volunteers.

Points to note:

- Topics seen as less important for the Family AOD LLE cohort is possibly due to them being more applicable to LLE roles within the Mental Health Sector and therefore less known



3.7 Training Not Recommended

The overwhelming response from respondents for this question was 'none', strongly indicating a belief that any training is good training for most LLE Family Volunteers /Workers in the survey.

Only 1 person indicated that they would not recommend **the** Cert**ificate** IV in AOD which appears to be a criticism of the course provider and also the irrelevance of the course content for LLE workforces.

Comment

"Took this with (redacted) - cobbled-together content, shoddy presentation, completely unrealistic and laborious work experience component. Also, not very relevant to LE work.

Doesn't teach anything about the AOD system that a smart person wouldn't learn in their first week at work."

3.8 Supporting Factors for Training

Several known studies have examined factors affecting training effectiveness and implications.

Further investigation is recommended.

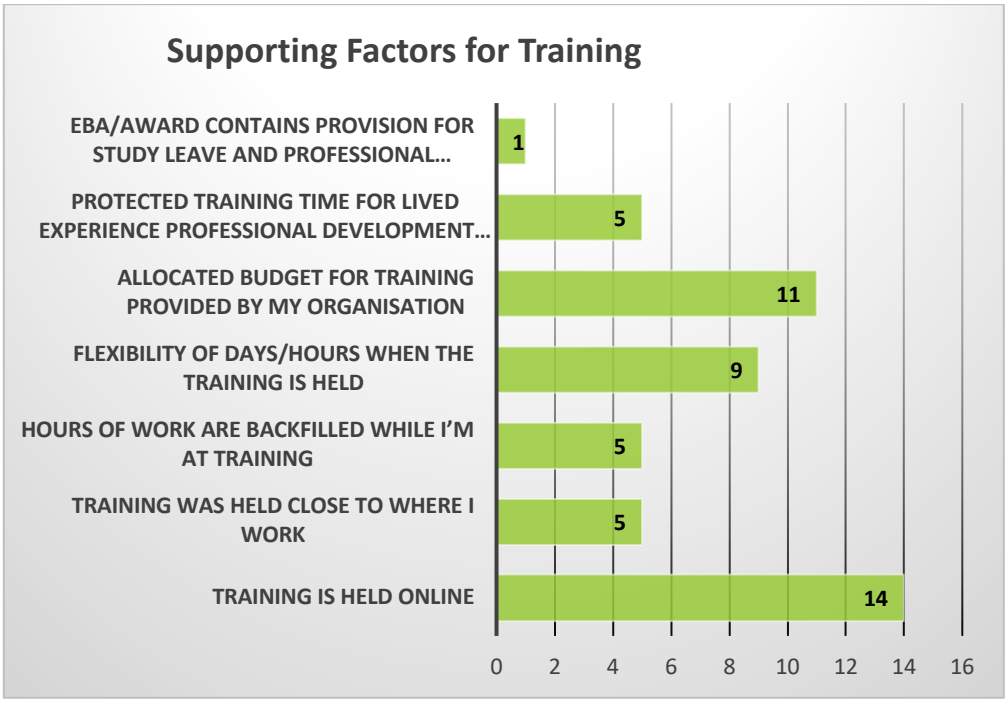
Findings for supporting factors in this survey indicate 3 prominent drivers for training uptake:

1. Training delivered on-line seems to be the biggest influence with 61% of respondents in support of this model of delivery
2. Allocation of budget resources by the organisations was indicated by 48% as an important supporting factor
3. Flexibility of training days was seen by 39% of respondents as a supporting factor to training

See the graph below for further details of identified supporting factors.

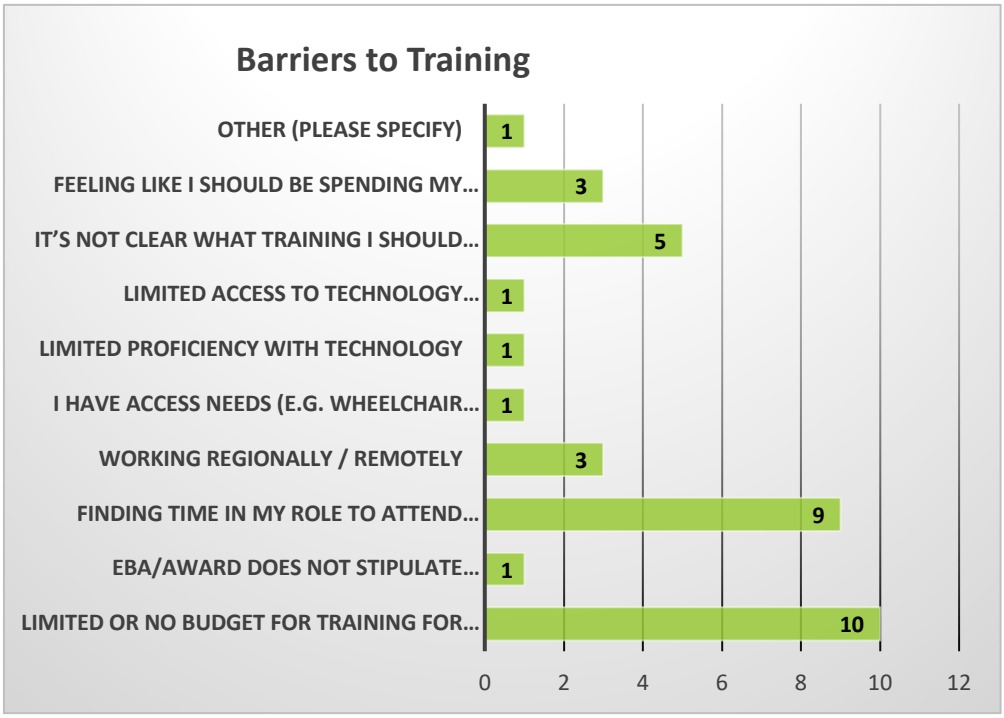
What was apparent from survey responses was that training needs to be accessible, flexible and something that they did not need to pay for themselves.

Organisations could also look within to find the most qualified and capable staff to deliver appropriate and relevant internal training to meet the needs of a varied workforce which may help mitigate organisational budgetary concerns.



3.9 Barriers to Training

Barriers to training were seen as important considerations to the development of a training program and there is much research to indicate that barriers impact on training-uptake and perceived credibility of training.



For the purpose of this survey, 9 reasons were explored. Respondents were also asked to provide other relevant comments to indicate barriers not listed so a broader outlook could be included for analysis. See graph on P 15.

By far the biggest barriers were seen as:

- Limited or no budget being allocated for training for my role and
- Finding time in my role to attend training

Both points are critical in addressing the issues of training availability.

It is recommended that this be given strong consideration by organisations to ensure continual and ongoing professional learning is provided to all staff and volunteers within their workforce.

3.10 Interest in Further Training/Types of Training

When asked if they would consider further training to either a Cert**ificate** III or IV, Diploma or a Degree, respondents had mixed feelings ranging from yes to unsure. Only 2 respondents indicated that they would not be interested in further training.

Figure 1 below indicates the percentage responses in each of 3 categories and it would appear overall that respondents in the Family AOD LLE Workforce would be interested in ongoing skills development and capacity building should their supporting factors for participation be adequately met.

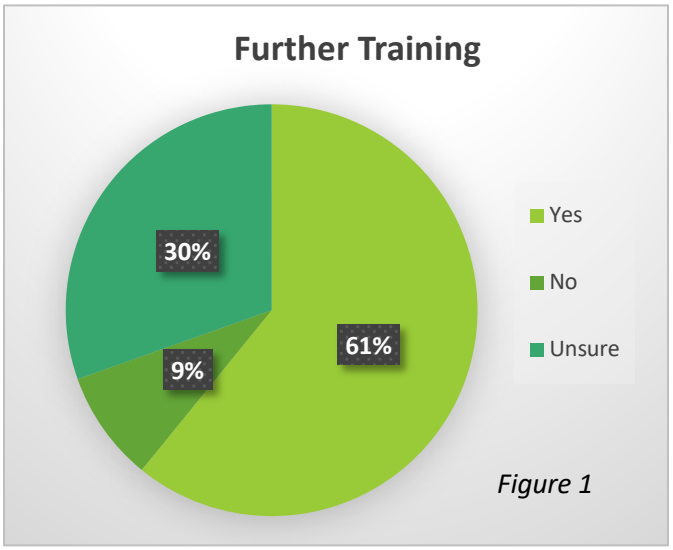


Figure 1

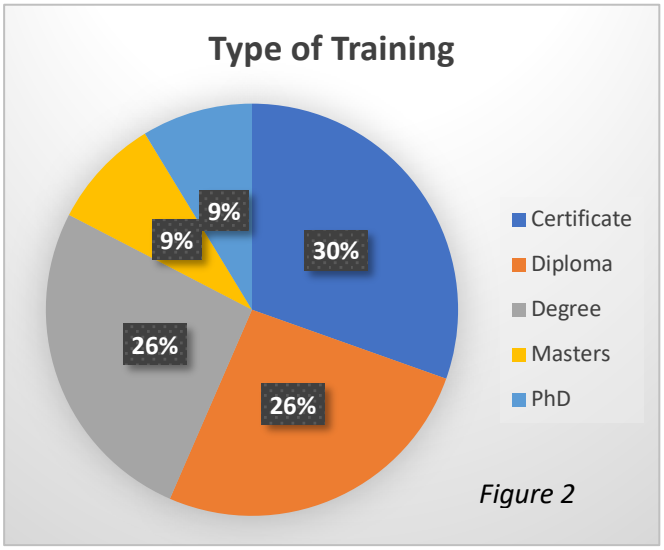


Figure 2

61% of respondents indicated they were interested in undertaking further study with 39% indicating that they were unsure or were not interested.

30% & 26% respectively indicated Certificate or Diploma studies. 26% indicated Degree qualifications.

2 people indicated a preference to undertake additional training in short courses.

Comments

- *"Shorter courses geared at specific aspects of the job seem more realistic and purposeful."*
- *"Short courses to start with."*

3.11 Barriers to Further Training

When asked about any barriers to further training respondents were varied in their responses.

- Cost of training was indicated by several people
- Time commitment when considering other responsibilities
- 2 people felt there was a lack of availability of training for LLE Family Peer Workers/Volunteers

Comments:

- *'Lack of availability for family workers. Courses seem focused on the needs of the person who uses AOD.'*
- *'Unaware of any higher education qualification in lived experience work'*
- Two comments of interest, which may indicate an unawareness in the sector/community for the needs of families are listed below:
    - *'I would not want to 'waste' a Commonwealth supported training place for lived experience training as I do not feel it is a very transferable skill, or that there are many related jobs- and may mean I can't access other comm. funded training.'*
    - *'I'm wary that these qualifications are sometimes just land-grabs by greedy institutions and self-serving academics. LLE workers need accessible and instantly applicable practical guidance from other practitioners. Too much academic theory, social crusading or clinical box-ticking all detract from the heart of the matter.'*

3.12 Other important support in first 12 months?

Some of the responses to this question deserve to be listed separately as they were strongly felt by several Family LLE Workers/Volunteers.

Organisational readiness appears to be mentioned in a number of these responses, and this was also discussed during Focus Groups with a number of participants indicating they had found a need to justify their roles to clinicians due to a lack of understanding by them.

In one Focus Group, a new Family Lived Experience CAG member spent considerable time teaching clinicians in the CAG what her role entailed.

A summary of additional comments is detailed below. Those in italics are directly copied:

- Social & Professional Support
    - Professional support and inclusion from staff and volunteers
- External Supervision

    - *"I had access to this, but quality supervision, including externally, is essential - probably more important than any course or qualification in my view."*
- Supportive Team & Culture
    - Supportive team and culture, inclusiveness and valuing of the role in the work environment, consumer participation feedback plays a role
- Have the opportunity to do placements
    - *"I sought out my own volunteer positions but isn't totally relevant to my course work."*
- Mentoring, supervision, debriefing & reflection sessions
    - So that workers are not isolated
- Don't Demonize the Family
    - *"I was well supported in Vollies role at first organisation, but Dip MH & AOD very focused on the person using, almost to the extent of "demonizing" families."*
- Organisational Readiness
    - *"I was in a very supportive organisation in my first volunteer peer role so had supervision, training, supportive work culture and training however in other organisations I have since worked at, I have tried to advocate for the organisation to embrace peer workforce and there has been reluctance, lack of respect for lived experience workforce or understanding of the value, stigma and ignorance etc so combating those would be most important."*
- Family AOD LLE COP
    - Speaking to the people already in these types of roles. The ability to interact with others working in a voluntary capacity.
- Financial Support
    - *"Financial support as I would need to take time away from my paid job to take on further study."*
- Little Training for LLEWs
    - *"When there is lived experience workers there is little training, and lower pay and conditions. Peer supervision and the COP is also important."*

4. Outcomes Summary

4.1 Survey Findings

4.1.1 Demographics

- After appropriate data cleaning, 23 survey respondents were identified as being eligible for inclusion in the survey analysis.
- Females strongly outweighed males throughout all age brackets – 76% to 19%, with the over 55's age bracket having the smallest imbalance of females to males. One person declined to respond to this question.
  This is consistent with all survey cohorts showing 69% female and 22% male with the balance identifying as non-binary, Gender Queer, Intersex or not specified.
- It is to be noted, that the lowest age bracket of 26-35 did not include any males. When correlated with the 'all cohorts' statistics, this is relatively consistent within age brackets.
- It was noted that 44% of respondents had a Post Graduate Tertiary qualification with 31% having Undergraduate tertiary qualifications**. The AOD family/carer respondents appeared to be one of the most educated of all the workforces surveyed.**
- The majority of respondents worked within the Melbourne Metropolitan area; Regional Victoria was only represented by 1 respondent with 1 person retired. This is in comparison to **the findings across all workforces surveyed in this project where** 75% worked in Metropolitan Melbourne, 13% in Regional Victoria and 5% Other.
- 90% of Family LLE workers/volunteers were in a primarily AOD service and 10% from a Dual Diagnosis service.
- Across all role categories within the Family LLE workforce who participated in this Project Survey, it was found that 69.57% were working in a voluntary role and only 26.09% being in paid work. 4.35% of survey respondents had both paid and voluntary components to their role.

4.1.2 Training

Survey results indicated that training needs must be immediately addressed by organisations employing both volunteer and paid LLE workers. It could not be clearly identified whether training identified through survey responses was provided by their organisation or had been financially self-supported and researched by LLE workers or volunteers.

Due to the question criteria, it could also not be identified if that training had been attended prior to their commencement at an organisation or within the first 12 months.

4.1.3 Identified Areas of Need for Training

4.1.3.1 Role Clarity & Organisational Readiness

Role clarity and Organisational readiness, or lack thereof, was a strongly identified need for all survey respondents and focus group participants.

Organisational readiness was seen as a systemic issue that needed to be addressed as many Family AOD LLE workers/volunteers found themselves having to justify their place in an organisation.

- Practice/Skills-Based Learning was seen to be particularly non-existent and was something that was highlighted in both focus groups and survey responses. Huge gaps in training available were identified and potential broad areas of learning were found. These findings, along with similar finding from the Focus Groups, formed the basis for the recommendations for introductory training.
- Capacity Building and Continuous Skills Development emerged as areas that many survey respondents indicated they were seeking.
    - Qualifications ranging from Certificate Level through to completing Post Gradual Tertiary and PhD's were listed as areas of interest.
    - 2 survey participants indicated short courses as their preferred option.
- Other identified areas
    - Being able to connect with like-minded LLE Workers and Volunteers through networks and Communities of Practice (COP) was seen as a strong need to enable peer-based learning and information exchange
    - Mentoring and supervision
    - Services that don't 'demonize the family' (do not understand or consider family needs).

4.2 Focus Group Findings

4.2.1 Demographics

4.2.1.1 Gender & Age

Four Focus Groups were scheduled for AOD Family LLE Workers and Volunteers. One was cancelled due to low numbers with registrations incorporated into one of the other three sessions. The total number of Focus Group participants was 12 across 3 groups.

Of those 12 participants 10 were female and 2 were male, which is consistent with survey results indicating more females than males work in the LLE sector.

4.2.2 Training

Huge gaps in training delivery were identified as major areas of concern causing people to feel anxious and ill prepared to commence their roles.

95% of participants indicated they sought their own training much of which was free or paid for personally. There were many areas of practice they would like training in.

Where training, of sorts, had been provided, it consisted of shadowing, mentoring by another LLE who had not been provided with formal training and a brief induction into the organisation.

Focus Group data was collated under the following headings in relation to training needs and this has formed a basis for our overall training recommendations for AOD Family LLE Workers and Volunteers.

4.2.2.1 Understanding and Working Within the System

- 100% of participants stated that they did not have a clear understanding of the AOD and MH systems and referral pathways both system-wide, and those offered through their agency. It was also stated that an understanding of the elements of the Youth AOD Sector was needed.
- 100% of participants stated they had no clear direction on commencement of the services available and referral pathways for families/carers
- 100% of participants said on commencement they did not have a clear understanding of the 'anachronisms' used which affected their confidence to do the role they were in.
- 100% of participants also stated that they had no guidance related to policy and legislative frameworks supporting AOD Family peer work

In summary, Focus Group findings indicate that training is needed for all LLE workers and volunteers in understanding all service systems within Mental Health, AOD and Youth service systems. It is recommended that training be inclusive of this within all services – (MH, AOD, Family, Justice and Youth services).

4.2.2.2 Role Clarity

- 100% of all Focus Group participants stated that role clarity was greatly lacking in their roles.
- They unanimously stated that they did not have a clear understanding of their roles, and what was expected of them, even after a couple of years in their positions.

- Position/Role Statements had not been provided to 85% of participants and many volunteers believed what was being asked of them was more than they had expected when they first signed on.
- All participants stated that they needed an understanding of how to work collaboratively with other professionals. This was complicated by the fact that many clinical staff did not understand or recognise LLE Workers/Volunteer roles and how these workers could complement clinical work and enhance the client experience.
- Approximately 25% of participants said that they found themselves needing to explain and justify their roles to clinical staff due to lack of understanding of LLE work and how it could be used to complement clinical work.
- 75% of participants stated that when they commenced their role, they had no clear understanding of the value of peer work and how they could best utilise their lived and living experience.
- 100% of participants stated that they had no clear direction of the limits of purposeful disclosure nor did they have guidance of how to differentiate between their own LLE and the role they held in relation to disclosure.
- All participants also stated that they felt they did not have the necessary skills to work with those who had different circumstances to them e.g., parents, siblings or partners
- Boundaries, privacy and confidentiality within their roles and those they were working with was of concern for all participants. No guidance had been provided to them and they felt they were left to their own interpretations and judgement.

In summary, Focus Group findings indicate that training needs to include a module on Role Clarity covering, at a minimum, the identified needs above. Organisational Readiness Training must also be flagged a requirement of all services prior to engaging LLE workers and volunteers.

4.2.2.3 Practice/Skills Based Learning

Practice/skills-based training came up strongly with all Focus Group participants in a variety of areas. A recommended training plan has been developed by the author as part of the project brief for AOD Family LLE Workers; it includes the points in the following table.

● Group facilitation skills	● Understanding empathy/compassion
● Advocacy – How to advocate for others	● Technology skills
● Managing conflict	● Dealing with aggression
● ASSIST training and responding to crisis	● Communication skills: - How to listen without giving advice - Holding the space

	- Active listening
● How to develop rapport	● Content learning for facilitating groups
● Working with people who have different circumstances e.g., parents, siblings, partners	● How to contain the group/helpline call
● Ongoing & continuous opportunities for learning	● Training in Dual Diagnosis, Mental Health & AOD, Gambling to allow a holistic needs assessment and referral recommendation

In summary, it is recommended that a comprehensive Training Plan for all current and prospective AOD Family LLE Workers and Volunteers containing a common needs theme as well as optional modules for specific skills needs relevant to varying role needs.

4.2.2.4 Workplace Wellbeing

All Focus Group participants spoke about feelings of burnout, triggering-situations which replicated their own experiences with their loved ones and how to deal with their own emotions.

100% of participants agreed that they had not had regular supervision provided to them, although some indicated that debriefing had been provided by their supervisor. It was felt that external supervision would be of extreme benefit to better support their wellbeing.

Main points identified are listed below:

- Self-awareness and self-care - how to identify if you're not "travelling well" and strategies to cope and enhance your own well-being
- Knowing what supports are available to you as a volunteer or paid employee e.g. supervision, debriefing, community of practice, mentoring
- Managing own emotions as a LLE worker/volunteer
- Knowing how to deal with my own triggers
- Networking, having the opportunity to connect with peers
- Managing vicarious trauma

In summary, it is recommended that training and information be made available to all AOD LLE Workers and Volunteers that supports their wellbeing, particularly supervision and EAP eligibility.

It is also strongly recommended that as part of Organisational Readiness Training, workplace wellbeing is highlighted as a need for all AOD Family LLE Workers and

Volunteers and is built into their EAP and Supervision budget expenditure and future planning.

5. Recommended content for introductory training for the AOD Family/Carer workforce

Based on findings from the project, the following is recommended as core content for the AOD Family/Carer workforce.

5.1 Fundamentals of family carer peer work

Scope of practice

- What is Peer Lived/Living (LLE) Work
- Types of LLE Roles/Role Clrity
  - Group facilitation
  - Advocacy
  - Peer Work
  - Advisory and consultant roles
  - Overdose prevention/harm reduction
  - NSP
- What Peer LLE Work Is Not
- What makes up a Family Unit
- Unique needs of Caregivers
- Understanding the Family Unit struggles & unique needs
- Self determination of Consumer vs Family Fear
- Understanding limits & boundaries of working relationships

Philosophy, values & types of peer work

- The Philosophy behind Peer LLE Work
- Recopricity in peer support
- The Values & Concepts of the workforce
- Spectrum of Types of Peer Support
  - Informal Peer Support
  - Formalised Peer Support
- Intro into Code of Ethics & Principles of Practice

5.2 Navigating the service system & Workplace

Sector

- Overview of the AOD, MH and Youth systems

- Forensic AOD system
- Navigating the system for consumers and families
- Catchment-based intake services
- Understanding the Mental Health Act 2014
- Services and supports for families
- Understanding Family and Carer Rights
- Knowledge of professional, legal & ethical frameworks

Workplace

- Understanding Workplace Legislation
- Leadership - supervisors, team leaders and coordinators
- Understanding Supervision
- How to deal with stigma & discrimination in the workplace
- Sharing LLE in the workplace
- Understanding power dynamics in the workplace
- Community of Practice
- Making Referrals - knowing how to refer and the pathways of referrals
- Big picture thinking
- Principles of reasonable adjustment

5.3 Standards and principles of practice

Understanding Standards of practice of Peer Support/LLE work

- Respect
- Advocacy
- Recovery
- Working in partnership
- Excellence

Applying Peer LLE principles in diverse environments

Core Values that underpin Peer Support/LLE work

- Equal and trusting relationships
  - Mutuality & reciprocity
  - Dignity, respect & trust
- Self-determination & personal strength
- Peer support is non-directive, strength based & recovery-focused
- Peer support is evidence based

5.4 Core Attributes of the Family Carer Peer Workforces

An Exploring of Self & Core Attributes

- Hope and possibilities
- Demeanor
- Communication
- Respect

- Self-Management and Resilience
- Flexibility and Adaptability
- Critical Thinking
- Self-Awareness & Confidence
- Teamwork & collaboration
- Personal integrity
- Continuous Learning & Development

5.5 Lived and living experience in practice: Concepts and methods

- Ethical responsibilities
    - Conflict of interest
    - Professional boundaries & relationships
    - Commitment to safe practices
- Safety, risk & legislation
- Domestic violence, financial or material abuse or exploitatin, psychological abuse, sexual abuse or exploitation, neglect
- Connecting with community resources
- Using your lived / living experience
- Building supportive relationships
- Family process of recovery and change
- Diversity & social inclusion
- Fostering self-determination
- Social determinants of health
- Building resilience through self-care and wellness plans
- Purposeful disclosure and mutuality
- Person-centred approach
- Trauma Informed approach
- Communication & barriers to communication
- Motivational Interviewing concept in LLE practice
- Active Listening
- Boundaries
- Doing with vs doing for
- Working with diverse people
- Stigma and discrimination
- Develop advocacy skills for families
- Recovery capital-understanding who is in circle of influence
- Managing conflict
- Crisis situations (self-harm, suicide), meta-competences & strategies
- Dual Diagnosis - understanding complications of comorbidity
- Gambling, AOD and MH relationship

5.6 Managing personal wellbeing and professional development needs

Self-care

- Self-care/awareness and tools to maintain wellness & resilience
- Vicarious trauma
- Burnout and compassion fatigue
- Reflective practice
- Moral and ethical dilemmas
- Exploring organisational supports - supervision & debriefing

Professional development

- Career planning
- Accessing professional development
- Volunteering, mentorships and placement opportunities
- Goal setting
- Continual improvement & lifelong learning

5.7 Elective modules

- Returning to the workforce skills
- Dual diagnosis (advanced)
- Technology basics – word, excel, PowerPoint, Zoom, Teams
- Group facilitation training (advanced)
- Working as a family/carer consultant in hospital and community settings (advanced)
- Helpline training
- Dealing with crisis and suicide (advanced)

6. Preliminary Recommendations

- Gender imbalance to be addressed to reduce the female / male bias in the LLE workforce.
    - Evidence to support this recommendation can be found on P 4, point 2.1
    - This can also be supported by summary data collected on Page 20 of this report
        - Females strongly outweighed males throughout all age brackets – 76% to 19%, with the over 55's age bracket having the smallest imbalance of females to males. One person declined to respond to this question.
        - It is to be noted that the lowest age bracket of 26-35 did not include any males.

  Evidence to further support the recommendation to address gender imbalance is also noted in:
    - *The National Alcohol & Other Drug Workforce Development Strategy 2015-2018, Outcome Area 2"*
    - *"Victoria's Alcohol and Other Drug Workforce Strategy 2018-2022, Workforce Snapshot, P4"*
- That further investigation and evaluation be designed and delivered to focus on workforce funding models for Family AOD LLE Workers in the Sector to provide support for the recruitment and retention of highly skilled and capable LLE Workforces to support families in distress.
    - Evidence to support this recommendation can be found on P 7, point 2.6 where a summary of all the AOD LLE Family Workers surveyed showed that 69.57% were working in a voluntary capacity, 26.09% in paid roles and 4.35% in both categories within the one role.
    - See the *National Alcohol and Other Drug Workforce Development Strategy 2015-2018, Outcome area 5: Improve child and family sensitive practice*
    - See *Victoria's Alcohol and Other Drugs Workforce Strategy 2018-2022, Peer Workforce Models-Expansion and support of the peer workforce.",* which states *"Defining and supporting pathways from 'service-user' to 'peer worker' is an important aspect of growing this workforce."*
    - See *Victoria's Alcohol and Other Drugs Workforce Strategy 2018-2022, KRA1: Improve workforce available, "Vision: Workforce planning, attraction, retention, utilisation and growth strategies deliver a workforce that meets community, service and worker needs and outcomes now and into the future."*
- Additional study be undertaken of the Mental Health and AOD LLE Consumer and Family Workforces, with a project timeframe agreed upon of > than 12 months from commencement

to completion, to ensure sound and valid data is generated on quantitative and qualitative studies relevant to training needs, allowing for identification of significant relationships within data sets.

- See Project Limitations at the beginning of this analysis

- Due to the limited sample size being very small, statistical tests may to identify important relationships or connections within the data set. It is therefore strongly recommended that further research in the same study is based on a larger sample size for more accurate results.
    - N=23

A cohort-specific Workforce Development Training (WDT) is developed specifically for AOD Family LLE Workers & Volunteers based on the content recommended in section 5 of this report, and that training be inclusive of a broad overview of all sectors to develop a non-siloed LLE workforce.

- See Survey and Focus Group summary analysis on pages 20 & 24, and recommended content in section 5 of this report.
- See *"Victoria's Alcohol and Other Drug Workforce Strategy 2018-2022, Page 14, Advanced practice series.", Page 15, LGBTQI capacity-building program & Implementation of the AOD worker capability framework.*

- That training be developed with an on-line training component to allow for self-paced learning within the Family AOD LLE Worker/Volunteer workforce.
    - See Page 15 of this report where it is shown that survey data indicates training delivered on-line is the biggest influence with 61% of respondents in support of this model of delivery
    - See *"Victoria's Alcohol and Other Drugs Workforce Strategy 2018-2022, Page 20, KRA 4: Improve worker health, wellbeing, safety and engagement, Priority Actions, Accessible and engaging training."*

- That an understanding of continuous ongoing improvement and capacity building be a strong focus of a coordinated approach to WDT and delivery for LLE Workers and Volunteers to develop capacity and capability.
    - Evidence to support of this recommendation can be found on Page 17, where it is shown in point 3.1, figure 1 that 61% of survey respondents are interested in further training to build capacity
    - See also *"Strategy for the Alcohol and Other Drug Peer Workforce in Victoria, page 7, Making the Vision a Reality-Actions, 1.2 AOD peer work is supported by a sector wide peer workforce development framework",*

- That organisations ensure that ongoing professional development for their LLE workforce be a crucial element of their service planning.

- Evidence to support of this recommendation can be found on Page 17, where it is shown in point 3.1, figure 1 that 61% of survey respondents are interested in further training to build capacity
- See *Victoria's Alcohol and Other Drugs Workforce Strategy 2018-2022, KRA 2: Build workforce capabilities and quality.*

- That organisations' Professional Development funds be inclusive of the training needs of all staff and volunteers.
    - Page of this report indicates that at 44% of the responses highlighted that a lack of funding for their professional learning was seen as one of the highest barriers to training. Many respondents also indicated that they had paid for their own training

- That Introductory Training Packages include a large component of Practice and Skills-based training which is further consolidated through a work placement program inclusive of shadowing and mentoring by more senior LLE staff and clinicians .
    - Evidence supporting this recommendation can be found on Page 17 where mentoring, placement opportunities and professional support were seen by many as important

- That the provision of external supervision be available for all LLE Workers and Volunteers.
  Focus Group participants emphasised the importance of external supervision for LLE Worker and Volunteer wellbeing. 100% of focus group participants agreed that they had not had regular supervision (P21) and felt that external supervision would be of extreme benefit to better support their own wellbeing, emotions, manage triggers, etc. On P17, one participant is quoted as saying:
    "I had access to this, but quality supervision, including externally, is essential - probably more important than any course or qualification in my view."
    - See also *Victorian Alcohol and Other Drugs Workforce Strategy 2018-2022, Page 22, KRA 4: Improve worker health, wellbeing, safety and engagement, Tailored supervision programs*