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Mental Health Commission

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Lived Experience (Peer) Workforce Project

PROJECT TERMS OF REFERENCE

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Lived Experience (Peer) Workforce Project Terms of Reference

1. Rationale

The utilisation of the Lived Experience (Peer)[1] workforce to assist wellbeing, continues to be recognised as an important role to support the consumer, carer, family or significant other in their journey of recovery/wellbeing. It does this by taking a person-centred, family-inclusive and culturally secure approach, walking alongside the person and fostering autonomy and empowerment in their perspective and choice of what wellbeing and or recovery is for them. Peer workers encourage engagement (mutuality, non-judgemental approach, easy rapport, reduced stigma, connecting to someone with a shared experience, feeling valued and heard), individualised support options, advocacy and flexibility. With these qualities, there have been many reported benefits for people with mental health and/or alcohol and other drug issues, their families, carers and significant others including:

- enhance service navigation;
- problem-solving;
- goal achievement;
- self-advocacy and self-worth;
- being able to forge a good life; and
- being able to exit services.

Peer support was also seen as important for supporting people to forge a 'good' life with purpose and meaning such as assisting in employment and workplace issues, family relationships and community inclusion[2].

Additionally, peer work approaches are effective in reducing hospital admission rates, assisting people on discharge and supporting them to gain access to the much-needed supports and resources to live well in the community. Put simply, peer work approaches are effective in assisting people to navigate problems in day to day living who might be at risk of re-admission without such prevention and community support[3].

Peer work is founded on the principles of empowerment, self-determination, human rights and social justice[4]. As such, peer workers in designated roles act as change agents within organisations in order to ensure that these principles are operationalised in the design, delivery and review of planning, policies and practices. This unique contribution by the Lived Experience (Peer) Workforce requires specific, nuanced readiness by the employing organisation to embrace and support both the Lived Experience (Peer) Workforce and the other workforces in this endeavour.

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[1] See Glossary of Terms acknowledging definitions and language used across both the Mental Health and Alcohol and Other Drug Sectors.

[2] Adapted from the WA Peer Supporters' Network. 2018. The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services**.** https://static1.squarespace.com/static/5cbec5be7a1fbd1c3c41ca41/t/5ce271c82cb6cf0001531544/1558344146347/The-Peer-Workforce-Report-2018.pdf

[3] Adapted from the Health Workforce Australia [2014]: Mental Health Peer Workforce Study.

[4] Framework for Mental Health Lived Experience (Peer) Work in South Eastern NSW.

Given that the implementation of peers into the workforce has proven to be effective for the consumer, their family member, carer and significant other, it is evident that both the worker and organisation would benefit from having a Lived Experience (Peer) Workforce Framework specific to Western Australia which focuses on promoting a thriving environment for the peer worker and organisation collaboratively to achieve better consumer outcomes.

It is important that this Lived Experience (Peer) Workforce Project (Project) and the resulting Framework are applicable to building the capacity of the peer workforce in a variety of clinical and community service settings across the mental health and alcohol and other drug sectors. Additionally, the Framework may provide a resource or foundation to inform the development of Frameworks in other sectors and areas of health that engage a peer workforce to promote and support mental health and wellbeing.

Furthermore, and whilst considering the scope (identified in section 2 of this document) of the Project the Mental Health Commission (MHC) recognises that the peer workforce includes people who do not necessarily identify in designated peer worker roles. That is, people who have a personal lived experience of mental health and/or alcohol and other drug issues (including families, carers and significant others) and work in other roles throughout the sector. In Australia, approximately 65%[5] of the drug and alcohol workforce often draw on their own lived experience to support the individuals and families using services, however, do not consider or work under the banner of "peer". In mental health, there are more designated peer work roles but overall less people in other roles who identify as having a lived experience.

It is noted that drawing from or using one's unique lived experience whether in a designated peer role or not aims to promote the same positive outcomes including fostering hope and inspiration for a return to health. However, this Project aims to guide the development of the Peer (Lived Experience) Workforce as a discipline in its own right (like that of other health disciplines such as nursing, social work etc) and makes the distinction between being *informed by* one's lived experience and *operating from* one's lived experience.

Additionally, the MHC acknowledges the lived experience peer workforce is not limited to providing 'peer support' and includes such roles as peer and lived experience managers, advocates, educators, trainers, advisors, consultants, researcher and academics where people are engaged on the basis of their lived experience expertise in that specific professional area.

Incorporating all the various aspects of the Lived Experience (Peer) Workforce will be highly valuable and essential to the work of this Project which aims to guide the development of a thriving state-wide peer workforce across the mental health (including suicide prevention) and alcohol and other drugs sector.

Language is important and through discussions with key stakeholders the MHC understands there are variances between the mental health and alcohol and other drug sectors. As the national Lived Experience (Peer) Workforce Guidelines are due to be released in 2021, this Project aims to be consistent with these Guidelines while at the same time highlighting and respecting the nuances between the sectors.

[5] https://nceta.flinders.edu.au/workforce/alcohol-other-drugs-national-workforce-survey

This Project seeks to deliver on the following strategic objectives:

1. WA State Priorities Mental Health, Alcohol and Other Drugs 2020 – 2024
    a. Sector Development
        i. Workforce - Implement Workforce Strategic Framework release package:
            - Peer Workforce Capacity Building
    b. Peer workers across the sector
        i. Peer worker framework
2. Workforce Strategic Framework
    a. Building the capacity of the peer workforce
        i. The Mental Health Commission will develop a co-designed approach and strategies to build the capacity of the peer workforce across the mental health and alcohol and other drug sectors.

Through linkages with the Mental Health Leads Sub Committee and the interagency Chief Officers Group tasked with progressing Recommendation 25 of the Sustainable Health Review, the Project will also inform the Mental Health Workforce Planning Project being undertaken by the Department of Health, that includes as part of Phase 2, the development and implementation of a 5-year workforce plan to build workforce capacity, capability and sustainability.

2. Purpose / Scope

The Project aims to guide the development of a thriving state-wide Lived Experience (Peer) workforce across the mental health (including suicide prevention) and alcohol and other drug sector. The Project will be informed by existing work including peer workforce reports, studies and guidelines and aims to be consistent with the National Lived Experience Peer Workforce Guidelines (released mid-2021). The final outcome of the Project, including a Framework and strategies to build capacity of and for the Peer Workforce, will be co-designed and tailored to a WA context, taking to account the perspective and intricacies of both the mental health and alcohol and other drug sectors are reflected.

The Project will be guided by the principles, strategies and approaches outlined in the Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025.

In scope

The Project will be State-wide and include:

- Consumer, carer and family peer workers in the mental health (including suicide prevention) and alcohol and other drug system in both paid and volunteer roles;
- Government and non-government organisations that employ or are looking to employ a peer workforce;
- An understanding of the impact of the National Disability Insurance Scheme on the peer workforce, particularly the introduction of Recovery Coaches[6]; and

[6] Participants will have the option of selecting a recovery coach with lived experience or a recovery coach with learnt knowledge of psychosocial disability and mental health (some of which are peer workers and some are not). https://mycarespace.com.au/resources/what-is-a-recovery-coach-under-the-ndis

- Specialised aspects of the peer workforce within (but not limited to) Aboriginal, LGBITQ and Culturally and Linguistically Diverse communities. Additionally, lived experience perspectives from young people, eating disorders, suicide, criminal justice system, disability and involuntary treatment etc.

Out of scope

- Peer workers who are under 16 years of age[7];
- Peer workforce outside of the focused areas of mental health and alcohol and other drugs; and
- People with a lived experience who are employed in other roles that are not specially designated as Peer (Lived Experience) Workers.

It is acknowledged that peer workers operate in other sectors (for example first responders, defence, mining etc) however while this Project does not exclude these peer workers, the Project will mainly focus on peer workers in the mental health and alcohol and other drug sectors.

3. Objectives

The Project will:

1. define the key qualities and attributes of the peer workforce;
2. define the values and principles of the peer workforce by exploring key questions to determine what a thriving mental health and alcohol and other drug peer workforce requires including support, training, supervision and career pathways;
3. outline what current gaps exist in the peer industry from a consumer, carer, worker and organisational viewpoint;
4. map the current service environment where peer workers are providing voluntary and paid services;
5. outline the requirements for organisational readiness across a range of business areas including Human Resources (People and Culture) and finance, to support and integrate a peer workforce.
6. develop a mental health and alcohol and other drug Peer worker framework that provides industry and service direction on how to build peer workforce capacity across the system.
    a. demonstrate how a peer workforce can best support and enhance service provision and consumer outcomes across prevention, support and treatment in government and non-government services; and
    b. demonstrate how a peer workforce can best be incorporated into prevention, support and treatment teams to ensure their work is viewed as a highly skilled, legitimate, unique, supported and valued profession.

The Project will investigate and recommend how current peer workforce capacity could be optimised, reconfigured, enhanced, adapted or expanded as well as identifying where new peer work services and supports could be developed.

[7] It is suggested that designated peer workforce roles either paid or volunteer for people under 16 years of age would be unlikely due to the recency of their lived experience and duty of care required by employers.

4. Governance

The Project will be governed by a Project Steering Committee who will guide the work being undertaken by the MHC Project Team and consist of members representing the following portfolio areas:

- MHC (Co-Chair)
- Family Carer/Community (Co-Chair)
- MHC Workforce Strategic Framework
- MHC System Engagement
- Consumer portfolio
- Peer Practice Expert Group (PPEG) Representative
- Sector Reference Group (SRG) Representative
- Health Service Provider portfolio
- Primary Care/Community portfolio
- Mental Health portfolio
- Alcohol and Other Drug portfolio
- Aboriginal Heath Portfolio
- Suicide Prevention Portfolio

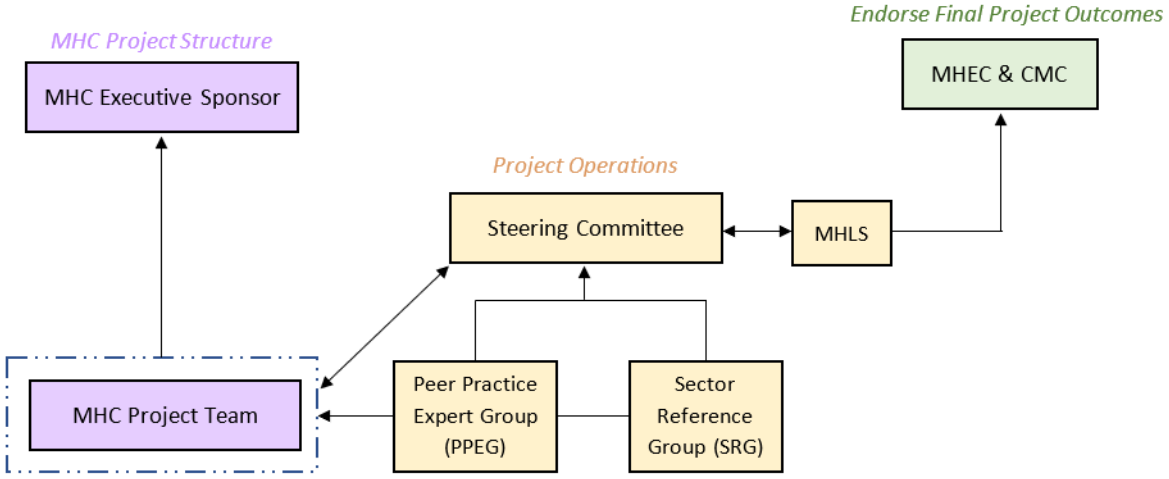
As the Project is a Key State Priority, the Mental Health Executive Committee (MHEC) and Community Mental Health and Alcohol and Other Drug Council (CMC) are responsible for the final endorsement of the Project.

To inform the work of the Project, the MHC Project Team has established two key stakeholder advisory groups including a Peer Practice Expert Group (PPEG) and a Sector Reference Group (SRG). Further targeted consultation may be established throughout the life of the Project and will be aligned to this Governance structure.

The PPEG and SRG will work with the Project steering Committee to:

- Encourage co-design approaches and engagement methods that support the project objectives;
- Assist with engaging stakeholders and promoting the work of the project; and
- Provide input and feedback to the development of documents throughout the life of the Project.

The below figure depicts the Governance of the Project.



5. Method

The Project consists of four overlapping key components:

- Establishment of the PPEG, SRG and Project Steering Committee;
- Peer workforce mapping;
- Engagement with stakeholder groups; and
- Data analysis, reporting and development of Framework and recommendations.

The MHC Project Team, consisting of the Project Officer, Consumer Advisor and Principal Policy Officer of System Engagement, will be guided by the Project Steering Committee and work in partnership with the SRG and PPEG. The Project Team will lead the development of the Project and engage with stakeholders including:

- Consumers, family, carers and significant others;
- Lived Experience Peer Workers;
- Peak Bodies and key systemic advocacy groups from the mental health (including suicide prevention) and alcohol and other drug sectors;
- Department of Health and the Western Australian Primary Health Network (WAPHA); and
- Government and community mental health and alcohol and other drug service providers.

6. Interdependencies

The Steering Committee will liaise regularly and closely with the MHC Project Team who will lead the project and collaborate with the stakeholders including the PPEG, SRG and any other Sub-Committees or Working Groups established as part of this project.

The emerging peer workforce in Western Australia is dynamic and has evolved considerably over several years. A number of Lived Experience (Peer) projects, programs, evaluations and pieces of work have been or are currently being undertaken. To avoid duplication, it is important to recognise, and build on this work by partnering with organisations including service providers, peak bodies, educational and training bodies who have championed peer work in Western Australia.

Cooperation and support from the mental health and alcohol and other drug sectors, consumers, family members, carers, peer workers and service providers are vital for the creation, strategic advice, critique, endorsement and implementation of the Project and its outcomes. Relationship building and the co-design approach to the creation of the Framework is fundamental for this to occur in line with the Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025.

As previously stated, the Project aims to be consistent with the National Lived Experience Peer Workforce Guidelines and will be informed by existing resources including (but not limited to):

1. Towards Professionalisation. A Project to undertake a feasibility study into the establishment of a member based organisation for the peer workforce in Australia. Private Mental Health Consumer Carer Network (Australia). 2019.
2. Peer Work Strategic Framework. WAAMH. 2014.

3. The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services. WA Peer Supporters' Network. 2018.
4. Workforce Development in Community Mental Health Final Project Report. WAAMH. 2017.
5. Increasing and Improving Community Mental Health Supports in WA. WAAMH, and the Centre for Social Impact, UWA.2020.
6. Comprehensive Alcohol and other Drug Workforce Development in Western Australia: Full Report. Western Australian Network of Alcohol and Other Drug Agencies (WANADA). 2017.
7. The Role and Value of Peer Work. CoMHWA. 2021.
8. Peer Workforce Models in Alcohol and other Drug Treatment. Lives Lived Well.
9. Establishing an Effective Peer Workforce: A Literature Review. Mind Australia. 2014.
10. Mental Health Peer Workforce Study. Adelaide SA: Health Workforce Australia. Health Workforce Australia. 2014.
11. Strategy for the Alcohol and Other Drug Peer Workforce in Victoria. Self Help Addiction Resource Centre. 2019.
12. Mental Health and Alcohol and Other Drug Consumer, Family and Carer Peer Work Frameworks and Strategies from Victoria, Queensland, New South Wales, South Australia and Tasmania.
13. Discussion Paper: Alcohol and Other Drug Peer Workers (2020) — Drug Education Network Inc.
14. Peer Support Themes. Report prepared for AOD Collaborative Group. Auckland: Julian King & Associates Limited – a member of Kinnect Group. 2014
15. Outcomes of the WANADA and Alcohol and Other Drug Consumer & Community Coalition, alcohol and other drug mapping exercise being undertaken in 2021.
16. Outcomes of recent peer survey undertaken by CoMHWA.
17. CHOICES Post Discharge Project: Evaluation Report. RUAH, WAPHA, UWA.

The final outcome of the Project will include a Framework and strategies to build capacity of the Peer Workforce and will ensure the perspective and unique contributions of both the mental health and alcohol and other drug sectors (government, community managed and private) are reflected and will be tailored to the unique context of WA.

7. Related Documents

- Consultation Plan
- Peer Workforce Steering Committee Terms of Reference
- Peer Practice Expert Group Terms of Reference
- Sector Reference Group Terms of Reference

Glossary

Lived experience

Any person who identifies as having a current or past personal experience of psychological or emotional issues, distress, mental health and/or alcohol and other drug-related issues, irrespective of whether they have a diagnosed mental health condition and/or alcohol and other drug-related issues and/or have received treatment.

This definition also extends to family and friends who have personal experience of providing ongoing care and support to a person who has lived or living experience as outlined above[8].

Consumer

While a contested term, it is used frequently in Australia and the United States. Whereas in the UK and New Zealand, the term 'service user' is more frequent. Additionally, client, patient, resident, participant or 'expert by experience' are also used. Another term also in many countries is CSX which stands for consumer/survivor/ex-patient. This latter term seeks to signal the emancipatory aspect of peer work, which is to go beyond service centrist thinking, toward solutions outside of service-land responses such as community development approaches and citizenship.

Carer

This too is a highly contested term, given associations with the notion of 'care' and its implication of passivity, charity, dependence, and burden. Increasingly, carer and family member peer spaces are rethinking such assumptions and working to consider the depth of the relationships and practices involved in caring and moving more toward actively surfacing the autonomy and self-determination and inter-dependence (how technologies are supportive, limiting, or both). Furthermore, as modalities such as open dialogue become more well known, the relational elements are highlighted, and the focus is on what is between people rather than within only some people. This, alongside burgeoning models of personalisation (NDIS) and the capacity to move beyond being passive patients to active citizens (citizenship) provides a nuanced and specialist knowledge base for the carer/family peer workforce.

Lived Experience (Peer) Workforce

The National Lived Experience (Peer) Workforce Development Guidelines acknowledges and promotes Lived Experience (Peer) Work as a discipline in its own right.

Lived Experience, when referring to designated roles or the LE workforce, is capitalised to distinguish the requirement of members of the Lived Experience workforce to bring their lived and learned expertise to the range of designated roles. This is distinct from members of other workforces who may bring a personal or family/carer perspective however, who are not required, employed or in some cases authorised to bring this perspective to their work. Instead their positions are informed by different priorities and/or disciplines, and as a result, are not part of the designated Lived Experience Workforce.

Peer Work

Peer workers are people who are employed in designated roles (either paid or volunteer) to primarily use their personal lived experience of emotional issues and distress, mental ill health and/or alcohol and other drug issues or experience as a family member/carer of supporting an individual in these areas to inform their work in conjunction with relevant

[8] Mental Health Commission. 2018. Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025. Perth: Government of Western Australia. https://www.mhc.wa.gov.au/media/2532/170876-menheac-engagement-framework-web.pdf

training and development Peer work roles include (but not limited to) support workers, representatives, advisors, academics, consultants, educators, trainers, evaluators and researchers[9].

It is noted that mental health peer work has its history in activism and reform due to its troubled history of its treatment and silencing of people deemed as 'mentally ill' / psychiatrised individuals over the ages. This work differs to other forms of peer work such as nursing mother's association but is more closely aligned with the disability space in terms of its emancipatory aims.

Recovery

Recovery is a term with different meanings in the mental health and alcohol and other drug sectors. Recovery means different things to different people. Of note, the strategic decision taken by the National Framework for Recovery-Oriented Mental Health Services (2013) (Australia's guiding document on recovery) was to recommend 'Personal Recovery[10]' as differentiated from Clinical Recovery or Social Recovery (Rehabilitation). Personal Recovery is defined as 'being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issue'. In regard to alcohol and other drug use, it may or may not involve goals related to abstinence[11].

Regarding the evolution of the recovery concept in the alcohol and other drug sector, it has been noted that, the general consensus was that recovery (that is, abstinence) from using alcohol or other drugs was the main focus in the earlier days, but it became apparent to work on other areas of life in order to maintain recovery. 'White-knuckled' abstinence with no improvement in life did not constitute recovery for this group[12].

Historically, in Australia many alcohol and other drug treatment services were outside the healthcare system (largely by charitable organisations in institutions). Much of the treatment was focussed on abstinence, Now, alcohol and other drug treatment is seen as part of the wider healthcare system and the person receiving treatment and support works in partnership with their health care team to identify the goals and outcomes to be attained, and there is a continuum between harm reduction and abstinence-based services.[13]

This recovery concept does not adhere to the use of the "recovered" or "recovering" "addict" or "alcoholic" but instead embraces the idea of the recovery of a quality of life, whatever that means for the consumer – including secure housing, social connection, employment, and other personal goals[14].

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[9] Adapted from Mental Health Commission. 2018. Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025. Perth: Government of Western Australia. https://www.mhc.wa.gov.au/media/2532/170876-menheac-engagement-framework-web.pdf

[10] Slade, M. (2009). Personal recovery and mental illness: A guide for mental health professionals, Cambridge, UK: Cambridge University Press. (see specific chapter 'what is recovery' (pp. 35-43).

[11] Mental Health Commission. 2018. Working Together: Mental Health and Alcohol and Other Drug Engagement Framework 2018-2025. Perth: Government of Western Australia. https://www.mhc.wa.gov.au/media/2532/170876-menheac-engagement-framework-web.pdf

[12] Government of Western Australia Mental Health Commission. 'AOD Recovery: Consumer Perspectives', May 2018. https://www.mhc.wa.gov.au/media/2382/aod-recovery-consumer-perspectives.pdf.

[13] National Framework for Alcohol, Tobacco And Other Drug Treatment 2019–2029. https://www.health.gov.au/sites/default/files/documents/2020/08/national-framework-for-alcohol-tobacco-and-other-drug-treatment-2019-29.pdf

[14] Discussion Paper: Alcohol and Other Drug Peer Workers (2020) — Drug Education Network Inc. http://interactive.den.org.au/toolbox/DEN_DiscussionPaper_AlcoholAndOtherDrugPeerWorkers_2020_Ver1.0.pdf

Other types of Recovery include:

- **Clinical Recovery**

  Primarily defined by mental health professionals and pertains to a reduction or cessation of symptoms and 'restoring social functioning' (Victorian Department of Health 2011; Slade, 2009)[15].

- **Social/ Functional Recovery**

  Functional recovery includes education, employment, physical health and stable accommodation[16].

- **Relational Recovery**

  The emerging notion of relational recovery acknowledges that recovery is inherently as social process where consumers' personal experiences of hope, healing and empowerment are seen as inseparable from the social and cultural milieus from which they emerge[17].

- **Recovery as Citizenship**

  "Recovering citizenship" as a concept and metaphor to capture the individual recovery process within the context and goal of a life in the community that the citizenship framework supports. Citizenship can be defined as a strong connection to the 5 Rs of the rights, responsibilities, roles, resources and relationships that a democratic society makes available to its members through public and social institutions, the ''associational life" of voluntary organisations, and social networks and everyday interactions. Further, a sense of belonging in one's community and society both supports and is supported by a strong connection to the 5 Rs. This sense of belonging must be validated by other's recognition of one's valued membership in society[18]. Another associated concept connected to recovery is that of citizen capital (sometimes described as recovery capital), this concept goes across both mental health and AOD.[19]

Acknowledgement of other peer related definitions:

The WA Peer Supporters' Network 2018 Peer Workforce Report: Mental Health and Alcohol and Other Drug Services[20] provides the following definitions:

- **Peer support:** a relationship of respect, support and reciprocity between people who mutually identify a significant shared identity and/or experience.

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[15] A national framework for recovery-oriented mental health services: Policy and theory. Commonwealth of Australia 2013

[16] University of Melbourne, Faculty of Medicine, Dentistry and Health Sceinces. See an excellent critique of Social Recovery in: Coleman, R. (2011). *Recovery: An alien concept?* (pp. 28-62). Isle of Lewis, Scotland: P & P Press.

[17] Robertson, R., Obradovic, A., Morgan, B. (2016). Relational recovery: beyond individualism in the recovery approach. *Advances in Mental Health, 15*(2), 108-120. https://www.tandfonline.com/doi/abs/10.1080/18387357.2016.1243014

[18] Recovering Citizenship. Rowe, Michael. Davidson, Larry. 2016/01/01. The Israel journal of psychiatry and related sciences.

[19] WA MHC. (2018). Individualised Community Living Strategy (ICLS) Program Service Program Guidelines, Government of WA Mental Health Commission. https://www.mhc.wa.gov.au/media/2791/guidelines-individualised-community-living-strategy-guidelines-2018.pdf (page 15-16 references Citizen Capital)

[20] WA Peer Supporters' Network. 2018. The Peer Workforce Report: Mental Health and Alcohol and Other Drug Services. https://static1.squarespace.com/static/5cbec5be7a1fbd1c3c41ca41/t/5ce271c82cb6cf0001531544/1558344146347/The-Peer-Workforce-Report-2018.pdf

- **Peers:** people who mutually identify as having a significant shared identity and/or experience.
- **Peer workers:** workers whose identity as a peer is an essential requirement of their role, including individuals, families and carers, and including people in paid and volunteering roles.

The Private Mental Health Consumer Carer Network's 2019 Towards Professionalisation, a Project to undertake a feasibility study into the establishment of a member based organisation for the peer workforce in Australia[21], provides this definition:

- **Peer work, peer workers and peer workforce** include all workers in mainstream or alternative mental health services or initiatives who are employed to openly identify and use their lived experience of mental distress or as a carer supporting someone with mental illness as part of their work. As this workforce develops, there is a greater need to create new roles and define the boundaries between them.

Victorian Alcohol and other Drug, Peer Workforce Community of Practice states:

- a **Peer Worker** utilises their lived experience of alcohol and other drugs, plus skills learned in formal training, to deliver services in support of others.

The term peer can refer to people with a shared identity, culture, job or activity; or experience. The term lived experience is often used to describe what it is that makes someone a peer [22].

[21] Towards Professionalisation. A Project to undertake a feasibility study into the establishment of a member based organisation for the peer workforce in Australia. Private Mental Health Consumer Carer Network (Australia). 2019. https://www.mentalhealthcommission.gov.au/getmedia/97a154cd-7b72-4577-9562-4077c33820d2/Towards-Professionalisation-literature-review

[22] Peer Workforce Models in Alcohol and other Drug Treatment. Lives Lived Well.