

**Lived Experience Leadership Roundtable
(Queensland)**

**Productivity Commission
Inquiry into Mental Health**

**Post Draft Submission
2020**

Drafted by Chérie McGregor and Dr Louise Byrne
on behalf of the Lived Experience Leadership Roundtable

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

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

About the Lived Experience Leadership Roundtable

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

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

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

Draft Report Reform approach

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

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

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

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

Co-design and Co-Production

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

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

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

Royal Commission into Victoria's Mental Health System Interim Report

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

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

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

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

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

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

We advocate that the final report

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

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

Blue Knot submission 47

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

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

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

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

About the Lived Experience workforce

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

Jackie Crowe, Former National Mental Health Commissioner, 2014

For approximately a decade, government mandated standards, frameworks and policies have advocated mental health services incorporate diverse Lived Experience roles in mental health service delivery. For almost as long, Lived Experience workers, advocates, researchers and governments have acknowledged and debated the need for systemic Lived Experience workforce development and career pathways linked to nationally recognized vocational qualifications and standards.^{4 5 6 7} The recommendations included in the 2010 MHCCF consumer and carer identified workforce position statement⁸ and the 2014 *Mental Health Workforce Australia Peer Workforce Study*⁹ remain equally valid and (despite some progress) largely unaddressed in 2020. Significant recent development in acknowledging and formalising the paid contribution of people with a Lived Experience has occurred in Queensland, including the 2019 release of the *Queensland Framework for the development of the Mental Health Lived Experience Workforce*¹⁰ and the *Queensland Health Mental Health Framework Peer Workforce Support & Development 2019*¹¹. The pending release of the National Peer Workforce Development Guidelines, a directive of the Fifth National Mental Health and Suicide Prevention Plan, will further promote the credibility and ongoing development of Lived Experience collaboration and contribution nationally.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We advocate the final report

- 1. Emphasise the central role that Lived Experience workers play in reforming mental health services**
 - 2. Adopt the definitions of the Lived Experience workforce used by the Queensland Framework.**
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Draft Recommendation 11.4 Strengthening the Peer Workforce

Short Term Recommendations

National Guidelines

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

Draft Recommendation 11.4

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

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

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

We advocate that the final report include recommendations to ensure that

- 1. The updated National Mental Health Workforce Strategy integrates and emphasises recommendations from the pending National Peer Workforce Development Guidelines. This should include advice on how governments should financially contribute. Examples include providing seed funding to establish professional peaks**
 - 2. The updated National Mental Health Workforce Strategy includes an actionable list of priority areas, bodies responsible, and expected timeline**
 - 3. An independent body audit the progress of implementing the proposed actions for the sustainable and supported development of the Lived Experience workforce nationally**
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¹³ National Mental Health Consumer & Carer Forum (NMHCCF). (2010) *Supporting and developing the mental health consumer and carer identified workforce – a strategic approach to recovery: A position statement*. NMHCCF, Canberra. Retrieved from <https://nmhccf.org.au/publication/supporting-and-developing-mental-health-consumer-and-carer-identified-workforce>

Occupational Representation

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

Draft Recommendation 11.4

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

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

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

especially concerns us if senior government positions are created to guide Lived Experience workforce development. Networks with the wider Lived Experience movement, understanding and application of the broader thinking in the movement are essential to the authenticity and efficacy of Lived Experience roles.

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

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

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

We advocate the final report amend Recommendation 11.4 to include

1. A prelude statement to identify that is essential that all initiatives intended to strengthen the Lived Experience workforce must be led by Lived Experience workers with the support of National, State and Territory governments and service providers.
 2. A recommendation for ensuring the perspectives employed in senior Lived Experience positions are aligned with the emerging discipline and its accepted values and principles as detailed in the Queensland Framework and National Guidelines.
 3. The requirement that any recommendations made by the NMHC must be generated through a co-production process involving the state-based consumer peaks and facilitated by Lived Experience leaders with experience employed in Lived Experience roles within the mental health sector.
 4. The requirement that National, State and Territory governments commit funding to support the development of the Lived Experience workforce, including establishing state and national peak bodies led by and for Lived Experience workers.
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Medium Term Recommendations

Lived Experience led education for all mental health professionals

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

Draft Recommendation 11.4

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

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

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

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

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

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

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

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

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

¹⁸ Obid op cit

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

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

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

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

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

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

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

We advocate the final report amend Recommendation 11.4 to

- 1. Increase the priority (from medium to short term) of Draft Recommendation 20.1 which advocates stigma reduction programs be incorporated in the initial training and continuing professional development requirements of all mental health professionals.**
 - 2. Include a recommendation for systematically embedding Lived Experience led education for mental health professionals. This should include Lived Experience involvement in curriculum development, delivery and evaluation.**
 - 3. Include a recommendation to provide and promote Lived Experience designated research scholarships at research higher degree (RHD) and early career, mid career and professorial levels.**
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Lived Experience practice qualifications and professional development

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

Draft Recommendation 11.4

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

a comprehensive system of qualifications and professional development for Lived Experience workers.

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

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

We advocate the final report amend Recommendation 11.4 to

- 1. Ensure that Lived Experience academics and Lived Experience workforce leaders are supported by relevant government agencies to drive a national review for developing a comprehensive system of qualifications and professional development for the Lived Experience workforce**
 - 2. Identify National, State and Territory governments and service providers have a responsibility to fund professional development for Lived Experience workers and provide scholarships to enable people with Lived Experience to participate in available training**
 - 3. Identify National, State and Territory governments fund Lived Experience academic positions to guide the development and delivery of education for Lived Experience workers**
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Summary of key points

Reform Approach

The final report should

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

Strengthening the Lived Experience workforce

The final report should

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

Appendix 1: Lived Experience Leadership Roundtable members

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

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

Appendix 2: Q-LEWN 2018 Survey Report

Appendix 3: Q-LEWN 2018 Strategic Planning Report

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