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MHLEEN's National Lived Experience Stocktake Survey 2024: PHN Commissioned Providers

Prepared by LELAN (Lived Experience Leadership & Advocacy Network) for the National PHN Mental Health Lived Experience Engagement Network (MHLEEN)

Mental Health Lived Experience Engagement Network

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ABOUT LELAN
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SUMMARY REPORT:

The National PHN Mental Health Lived Experience Engagement Network (MHLEEN) was established in 2018. Its core purpose is to:

- Integrate lived experience involvement into the commissioning of primary mental health services.
- Build and promote Lived Experience (Peer) Workforces.
- Create a national network of stakeholders, including Primary Health Networks (PHNs) to ensure the principle of 'nothing about us without us' is upheld.

In its first year MHLEEN conducted a nationwide stocktake survey with PHN's – The Lived Experience Stocktake Survey – and compiled case studies to build evidence on the expanded use of lived experience engagement and integration of Lived Experience (Peer) Workforces. Subsequent stocktake surveys of PHN's were run in 2020, 2021, 2022 and 2023.

In 2023 MHLEEN distributed the first Commissioned Service Provider Lived Experience Stocktake Survey to commissioned providers across the 31 PHNs. This survey served as a crucial benchmark for capturing attitudes, policies, and activities relating to embedding Lived Experience (Peer) Workforces, as well as integrating and partnering with lived experience (peer) representatives in planning, decision-making and evaluation of PHN commissioned services and programs.

Both surveys gathered quantitative and qualitative data to facilitate future comparisons, benchmarking and the development of relevant case studies for practice and policy. Data also identified critical trends and elucidated areas requiring further attention, thereby guiding resource allocation, continuous improvement strategies and ongoing discussions with commissioned service providers and lived experience (peer) representatives across the PHNs.

Scope of Report

In 2024 MHLEEN engaged LELAN to oversee the delivery of the Lived Experience Stocktake Surveys. The purpose of this engagement was to produce comprehensive Stocktake reports assessing the progress of PHNs and their Commissioned Providers in aligning with the Department of Health and Aged Care Guidelines and National Frameworks.

This report provides a summary and in-depth overview of findings from the Lived Experience Stocktake Survey for PHN Commissioned Providers distributed in 2024. 20 providers from Queensland, Victoria, New South Wales and Tasmania responded. Due to a lack of national data on PHN-commissioned providers, it cannot be determined what percentage of all providers this cohort represents.

The survey cannot be considered a full stocktake, however it offers valuable insights that can be extrapolated to anticipate current, emerging, and future trends and needs.

Funding and services

A PHN may provide funding to multiple providers for a range of diverse mental health and wellbeing services and programs. In total, approximately half of all PHNs funded the 20 providers who responded to the survey. One PHN funded eight programs, the highest number among the providers. Additionally, two PHNs funded six services, while one PHN funded four services and four other PHNs funded three services each.

Equally, providers may receive funding from more than one PHN for one or more mental health and wellbeing services or programs. Within this cohort, four providers received funding from five or more PHNs. Six providers were funded by between two and four PHNs, while ten providers received funding from a single PHN. In practice, each provider delivers a unique number of mental health services and programs funded by a distinct number of PHNs. For example, one provider delivery 15 services and programs funded by six PHNs.

The 20 providers deliver a total of 23 mental health services and programs among themselves. The most frequently commissioned services include alcohol and other drugs services, low intensity/early intervention services, group therapy, Headspace centres, and digital services such as telehealth and online services.

It is noted that less than half of the providers evaluated their funded services as a requirement of their funding. While some providers reported that they conduct evaluations as routine internal processes, others commented they did not evaluate funded programs unless mandated.

Lived Experience (Peer) Workforce roles

In the related section of this report, a summary table depicts the range of Lived Experience (Peer) Workforce positions employed by the 20 providers. This includes the type of roles, job classifications, contracted hours of work and salary ranges.

To briefly summarise, people with lived experience were employed in direct service delivery roles, such as Peer Support Workers, Family/Carer Peer Support Workers and Specialist Peer Worker roles. People with lived experience are also employed in roles that could be considered both direct/indirect service delivery, such as Team Lead and Coordinator roles through to management and executive positions. Consumer and Carer Representatives are integrated into organisation governance structures.

Other specialised lived experience (peer) roles exist, building on core knowledge and practice to provide expertise in areas such as education and training, auditing, research, consultancy, and participation in panels and advisory groups. These roles go beyond direct service delivery and contribute to mental health policy, service design, and broader systemic advocacy and change.

Providers report employing people with lived experience are employed into designated lived experience (peer) roles across various settings, including Alcohol and Other Drugs, Digital Service, Perinatal, Youth, LGBTQIA+, senior/aged care, family violence and harm reduction, consumer or carer and engagement. Most prevalently, providers employ people with lived experience into designated roles in Alcohol and Other Drug Services, Headspace, suicide prevention and low intensity/early intervention settings.

A total of 226 Lived Experience (Peer) Workforce members were reportedly employed. The highest number of workforce members employed by a single provider was 100. This provider received funding from 11

PHNs and provides 12 programs and services. Additionally, two providers each employ over 30 Lived Experience (Peer) Workforce members; one received funding from six PHNs and delivered 16 services and programs, and the second provider received funding from three PHNs and delivered two programs.

Providers reported a total of 213 Lived Experience, Consumer and/or Carer Representatives were engaged by providers. More than half of the providers currently engage Lived Experience, Consumer/or and Carer Representatives.

Integration of lived experience

Providers identified a wide range of training programs that are provided to Lived Experience (Peer) Workforce members. All providers offered access to ongoing professional development available to all staff. The most frequently provided training includes Cultural Sensitivity Training, Peer Supervision, Community Practice for Peer Workers and ongoing capacity building. All providers provided an induction and orientation program for Lived Experience Consumer and Carer Representatives. Others frequently offered training including engagement/advocacy training, Mental Health First Aid, Alternative to Suicide (Alt2Su) training and Lived Experience Leadership.

All providers who were recruited as Consumers and Carer Representatives in a range of activities ensured that these were paid roles. Induction, training and provision of resources and policies related to Lived Experience Engagement were also provided by these providers. Several providers implemented other policies including integrating Lived Experience into their Inclusion and Diversity Policy and processes across their organisation, Sitting Fee/Honorarium for Consumer and Carer Representatives, Lived Experience Consumer and Carer Representative Role Descriptions and have Terms of References in place.

More than half of the providers have engaged Lived Experience Consumer and Carer Representatives in governance and management structures. Providers identified a range of other reference groups and committees involving people with lived experience, including Trans and Gender Diverse, Disabled LGBTIQ and People living with HIV Reference Groups, Peer Guidance Group, Reconciliation Action Plan Working Groups, Program-specific governance groups, Lived Experience Training Hub Steering Committee and Course Advisory Group and an Editorial Committee.

Engagement frameworks

Most providers utilise an engagement framework, either one that is nationally regarded as a standard or one internally developed, to involve and partner with lived experience. Providers who do not use any specific framework instead use a range of strategies to guide their Lived Experience engagement activities, including developing practice, meetings and consultation processes.

Most providers use a range of evidence/data to monitor and measure the effectiveness of their lived experience involvement strategies and activities with people with lived experience. Half of these providers stated they were in the early process of developing mechanisms for data collection including feedback processes such as surveys, questionnaires (for both staff and people with lived experience), key performance indicators, and self-reported changes in knowledge and practice, through strategic planning meetings and minutes involving people with lived experience.

Some providers stated they did not gather any information in relation to involvement activities, unsure of the usefulness of this data. Other providers identified that they had always involved people with lived experience, however, they were unsure on how to report on it. This was a common theme in survey

responses.

Levels of involvement

More than half of the providers reported they have implemented a range of strategies and activities to partner with people with lived experience. These providers used strategies across the spectrum of all seven levels of involvement, evolved based on the IAP2 spectrum. Providers primarily use strategies to inform, educate and/or consult people with lived experience for most of their engagement and feedback processes and in the delivery of lived experience services or programs.

In summary, providers most often use strategies:

- **To inform** people with lived experience about how to find reliable health information/resources and to provide contact/help/ assistance information.
- **To educate** people with lived experience through support/peer groups, online resources/education technology, health promotion resources and self-help tools/supports, as well as 1 to 1 education between peers, between clinicians and consumers, and health promotion campaigns.

- **To consult** with people with Lived Experience that include experience service surveys, focus groups and workshops, target groups specific advisory committee and/or reference group, Targeted online surveys and questionnaires and community groups/networks.
- **To engage** with people with lived experience through committees, working groups, panels for recruitment, tenders and commissioning, or as lived experience (peer) researchers.
- **To co-design** with people with lived experience for project-based activities, the development of organisational frameworks or designing new and alternative solutions for mental health services and programs that are grounded in lived experience.

Examples of lived experience-led involvement was articulated through lived experience designed education and training, and people with lived experience leading or initiating projects and research-based opportunities.

Self-assessment on the integration and leadership of lived experience

The tables below provide a summary self-assessment on the level of integration and leadership of lived experience by commissioned providers. They are divided into areas determined to be established as well as areas for development, providing actionable insights into how lived experience can be further embedded in commissioned services.

Table 1. Integration of Lived Experience Self Assessed Areas

Area of LE Integration	Established Areas	Areas for Development
Service/Program	Standardised codesign approach across services and programs. Integrated Lived Experience (Peer) Workers across services and programs.	Lived Experience members on service and program steering committees and/or reference groups. Peer Led mental health programs (e.g. Alt2Su).
Organisation	People with Lived Experience participate as speakers/trainers as part of induction and orientation of staff and consumers Access to Lived Experience programs. Lived Experience roles reflect diversity of workforce, service users and the community.	Consumer Advisory Committee with Lived Experience Representative members. Lived Experience representation on advisory committee/reference groups for priority groups. Policy reflects, promotes and facilitates diversity and inclusion of People with Lived Experience.
Lived Experience Policy	Develop/review policies in codesign with People with Lived Experience. Specific engagement policies and processes in codesign with People with Lived Experience.	Lived Experience internal auditors and reviewers as part of clinical governance. Lived Experience partners in research and research evaluation.
Audit and Evaluation	Lived Experience internal auditors and reviewers in service delivery monitoring and review. Lived Experience partners in governance oversight and monitoring.	Audit engagement activities and Lived Experience contribution to ensure best practice. Collaboration with other organisations shared learning to improve Lived Experience involvement and engagement.

Table 2. Lived Experience Leadership Self Assessed Areas

Areas of LE Leadership	Established Areas	Areas for Development
Culture of support and allyship	All areas are established.	Advocate for meaningful and purposeful co-production. Refer consumers and families to Lived Experience workers.
Staff taking action	Understand the role and value of Lived Experience in the continuous development of recovery oriented mental health services. "Call out' practices that violate values and principles of Lived Experience work and personal recovery. Educate other colleagues on the value and benefits of Lived Experience work. Guide new Lived Experience workers and share knowledge of navigating internal processes and organisational systems.	Demonstrate tangible commitment to workplace conditions and policies that support authentic Lived Experience work. Actively engage Lived Experience (Peer) Workforce and Consumer and/or Carer Representatives in evaluation and quality improvement across the organisation.
Management and Governance Processes	Maintain the integrity of the Lived Experience (Peer) Workforce consistent with the values and principles of Lived Experience work. Encourage collaboration and networking Invest in professional development and career pathways to build Lived Experience leadership. Gather data to support evidence of Lived Experience (Peer) Workforce integration and outcomes to support evidence of best practice and funding.	Require service delivery to incorporate Lived Experience roles. Ensure funding guidelines are informed by best practice e.g. more Lived Experience leadership.
Funding and Policy	Ensure sustainable funding allocated for Lived Experience engagement and participation.	Require service delivery to incorporate Lived Experience roles. Ensure funding guidelines are informed by best practice e.g. more Lived Experience leadership.

SNAPSHOT OF ACHIEVEMENTS BY PHN COMMISSIONED PROVIDERS:

15%	Delivered ten or more mental health and wellbeing programs.
20%	Received funding from five or more PHNs.
23%	Have an Aboriginal and Torres Strait Islander Reference Group.
35%	Deliver Lived Experience (Peer)-led programs (e.g. suicide prevention program).
38%	Have a LGBTQIA+ Reference Group.
45%	Evaluated their funded programs.
45%	Develop policies in partnership with people with lived experience.
45%	Routinely use codesign in developing mental health services and programs.
46%	Have a Mental Health Lived Experience Reference Group.
50%	Of roles for people with lived experience reflect the diversity of service users and community.
65%	Employ people in designated roles within Lived Experience (Peer) Workforces.
65%	Involve lived experience representatives in governance.
70%	Utilise an 'engagement framework 'to inform strategies.
80%	Work to coproduce more effective alternatives to restrictive practices.
80%	Invest in training and career pathways to build leadership by people with lived experience.
85%	Gather data to support evidence of best practice and funding.
90%	Educate other colleagues on the value and benefit of lived experience work.
100%	Take a proactive stand against discrimination and prejudicial attitudes.
213	Lived Experience Consumer &Carer Representatives involved.
226	Members of the Lived Experience (Peer) Workforces employed.

1 INTRODUCTION:

There is a growing demand for mental health care to be grounded in people's lived experiences. Recent shifts internationally and nationally, however, have gone beyond this, moving towards the reform of current and new services and systems that fully embed and integrate lived experience at all levels: policy, service design/delivery, management and leadership, strategic planning, and governance. For mental health care to successfully embed and integrate lived experience, it is essential that we define what good looks like, identify the barriers and enablers, and develop robust evidence on impact and outcomes. In this approach, people with lived experience are not only considered valuable members of mental health workforces but are treated as partners across all levels.

1.1 The role of the Mental Health Lived Experience Engagement Network (MHLEEN)

The National PHN Mental Health Lived Experience Engagement Network (MHLEEN) was established in 2018. Its core purpose is to:

- Integrate lived experience involvement into the commissioning of primary mental health services.
- Build and promote Lived Experience (Peer) Workforces.
- Create a national network of stakeholders, including Primary Health Networks (PHNs) to ensure the principle of 'nothing about us without us' is upheld.

Brisbane North PHN was contracted by the Department Health and Aged Care to lead and oversee MHLEEN's conception and eventual operationalisation. The backbone support provided by Brisbane North PHN and MHLEEN for PHNs will change in 2025, with a regional focus for PHN planning prioritised and responsibility for embedding lived experience shifting to individual PHN's.

1.2 The Purpose and History of MHLEEN's Lived Experience Stocktake Surveys

In its first year MHLEEN conducted a nationwide stocktake survey of PHN's – The Lived Experience Stocktake Survey – and compiled case studies to build evidence on the expanded use of lived experience engagement and integration of Lived Experience (Peer) Workforces. In 2019, the Department released guidelines for Lived Experience (Peer) Workforces for PHNs, while MHLEEN continued to develop case studies on PHN and Commissioned Services Activities. Subsequent stocktake surveys were run in 2020, 2021, 2022 and 2023.

In 2023 MHLEEN distributed the first Commissioned Service Provider Lived Experience Stocktake Survey to commissioned providers across the 31 PHNs, with 129 providers completing the survey, in June 2023. This survey served as a crucial benchmark for capturing attitudes, policies, and activities relating to embedding Lived Experience (Peer) Workforces, as well as integrating and partnering with lived experience (peer) representatives in planning, decision-making and evaluation of PHN commissioned services and programs.

Both surveys gathered quantitative and qualitative data to facilitate future comparisons, benchmarking and the development of relevant case studies for practice and policy. Data also identified critical trends and elucidated areas requiring further attention, thereby guiding resource allocation, continuous improvement strategies and ongoing discussions with commissioned service providers and lived experience (peer) representatives across the PHNs.

1.3 Scope of This Report

In 2024 MHLEEN engaged LELAN to oversee the delivery of the Lived Experience Stocktake Surveys. The purpose of this engagement was to produce comprehensive Stocktake reports assessing the progress of PHNs and their Commissioned Providers in aligning with the Department of Health and Aged Care Guidelines and National Frameworks.

The 2024 Commissioned Service Provider Lived Experience Stocktake Survey marks the second systematic reflection on lived experience involvement and workforce development among PHNs and commissioned providers, with 20 providers responding from Queensland, Victoria, New South Wales and Tasmania. Due to a lack of national data on PHN-commissioned providers, it cannot be determined what percentage of all providers this cohort represents. The survey cannot be considered a full stocktake, however it offers valuable insights that can be extrapolated to anticipate current, emerging, and future trends and needs.

Survey results should be viewed as reflective of the 20 providers, not as a complete pool of the 31 PHNs. For this reason, no comparisons have been made with the 2023 survey results, where 129 providers responded.

The reasons for the disparity in response rates were not thoroughly investigated. However, it assumed that potential barriers to responding may include the survey length, breadth and depth of data requested, the level of circulation of the survey by providers (i.e. directed to the right staff), and time of year (for example, factoring in the reporting period). These factors will need to be considered if the survey is to continue.

This does not diminish the importance of the data provided in this survey. The survey structure is robust, and the survey questions drill down into the specific nature of strategies and practices used by providers to integrate lived experience in mental health service governance, quality improvement and innovation of service design and delivery. It supports individual providers to talk about and reflect on what matters and the value of Lived Experience involvement, to benchmark growth and level of embeddedness and why it is important, to evaluate strategies and practices and share key learnings for continued improvement.

In particular, the survey's two self-assessment components enable individual providers to evaluate and monitor progress, highlighting areas requiring attention and thereby guiding resource allocation and improvement strategies. In the transition to a regional PHN approach, this survey will be able to identify providers across their region that require additional support and focus on the self-assessed data that indicates the need for the development of key supports and resources to assist them to more actively embed Lived Experience (Peer) Workforce.

This report provides a summary and in-depth overview of findings from the Lived Experience Stocktake Survey for PHN Commissioned Providers distributed in 2024.

1.4 Key Changes to the Lived Experience Stocktake Survey for PHN Commissioned Providers in 2024

With MHLEEN's transition to a regional-PHN-based approach to providing lived experience advice, the 2024 iteration of the stocktake survey's for both PHN's and commissioned providers expanded to now include focuses on the following areas:

- Issues, barriers, enablers and strategies to evolve decision-making influence and authority of people with lived experience.

- Issues, barriers, enablers and strategies related to the integration of Lived Experience (Peer) Workforces, with careful consideration of relevant topics such as organisational culture, support and allyship, as well as staff actions, management and governance processes, funding and policy.
- PHN and provider-led self-assessments to determine readiness and preparedness to build and promote Lived Experience (Peer) Workforces and increased lived experience involvement.
- Future needs, solutions and innovations in the context of lived experience and in the PHNs.

Structurally, the 2024 iteration has been modified to enhance the completion experience for PHN's and commissioned providers, and to improve overall data quality and response accuracy.

The structure of the Lived Experience Stocktake Survey for Commission Providers is now as follows:

- Section 1: Survey Provider Details.
- Section 2: PHN Commissioned Service Providers.
- Section 3: Lived Experience (Peer) Workforce.
- Section 4: Integration of Lived Experience Engagement.
- Section 5: Self-Assessment of Providers Integration of Lived Experience.
- Section 6: Engagement Framework.
- Section 7: Levels of Involvement.
- Section 8: Levels of Involvement Case Studies.
- Section 9: Summary Self-Assessment of Lived Experience Engagement.

The IAP2 Levels of Public Participation, used as a standard to inform engagement strategies and activities, have been adapted to align more closely with the National Mental Health Commission's Consumer and Carer Engagement Guide while also being more consistent with contemporary lived experience language.

1.5 Resources that Inform and Align with the Lived Experience Stocktake Surveys

The Commissioned Service Provider Lived Experience Stocktake Survey have been informed by the following national guidelines:

- National Lived Experience (Peer) Workforce Development Guidelines[1], National Mental Health Commission.
- Consumer And Carer Engagement: A Practice Guide[2], National Mental Health Commission.
- National Safety and Quality Health Service Standards User Guide for Health Services Providing Care for People with Mental Health Issues[3], Australian Commission on Safety and Quality in Health Care.
- A National Framework for Recovery-oriented Mental Health Services[4], Department of Health and Aged Care.
- Fifth National Mental Health and Suicide Prevention Plan[5], National Mental Health Commission.

[1] The Guidelines and all associated resources are available for download on the National Mental Health Commissions website.
[2] The National Mental Health Commission. (2021). Consumer and Carer Engagement: A Practical Guide. Commonwealth of Australia: Canberra.
[3] Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards User Guide for Health Services Providing Care for People with Mental Health Issues. Sydney: ACSQHC; 2018
[4] Australian Department of Health. (2013). A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners And Providers. Commonwealth of Australia, Canberra.
[5] Australian Department of Health. (2017). The Fifth National Mental Health and Suicide Prevention Plan. Commonwealth of Australia, Canberra.

- Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All[6] and its aligned Toolkit[7], jointly commissioned by MHLEEN and the National Mental Health Consumer and Carer Forum (NMHCCF).
- MHLEEN Commissioned Provider Lived Experience Stocktake Reports and Case Studies (2018 – 2023).

1.6 An Important Note on Language

As recognised in The National Lived Experience (Peer) Workforce Development Guidelines, the future of mental health care lies in building recovery-oriented approaches and providing meaningful and relational support to people, driven by workforce members' own personal lived experiences and service experiences in designated lived experience (peer) roles. A thriving Mental Health Lived Experience (Peer) Workforce, is therefore, crucial.

To ground this work, we draw on nationally regarded definitions from the National Lived Experience (Peer) Workforce Guidelines.[8]

> *Lived Experience (Peer) Work or Practice is recognised as a unique and separate discipline that offers a valuable contribution to the mental health sector. As its own discipline, Lived Experience work has distinct values, principles, and theories that define Lived Experience work and the way it is practice…*
>
> *Lived Experience (Peer) Workers draw on their life-changing experiences of mental or emotional distress, service use, and recovery/healing, and their experiences, or the impact of walking beside and supporting someone through these experiences, to build relationships based on collective understanding of shared experiences, self-determination, empowerment, and hope. It is common to have experiences of distress and emotional pain, loss, stigma, discrimination, loss of rights, and navigating complex systems. Lived Experience also includes experiences and an understanding of losing and regaining hope, and emancipation. People's paths to healing, hope, and recovery are also different…*
>
> *A well supported Lived Experience (Peer) Workforce results in benefits for people accessing services, families, and service providers, as well as the broader community. Tangible benefits to mental health service providers include improved engagement with service users, more sustainable treatment outcomes, a reduction in critical incidents and the need for urgent care. This has flow-on benefits for the health workforce, improving staff retention and wellbeing…*

In this report, we also used terms such as designated or non-designated roles. When we refer to a designated lived experience (peer) role, we reference people with lived experience who have been directly

[6] Hodges, E., Leditschke, A., Solonsch, L. (2023). The Lived Experience Governance Framework: Centring People, Identity and Human Rights for the Benefit of All. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, Canberra.

[7] Hodges, E., Leditschke, A., Solonsch, L., Singh, J. & Blazewicz, T. (2023). A Toolkit to Authentically Embed Lived Experience Governance: Centring People, Identity and Human Rights for the Benefit of All. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, Canberra.

[8] Bryne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. (2021). National Lived Experience Workforce Guidelines: Growing a Thriving Lived Experience Workforce. National Mental Health Commission.

employed in positions aimed at applying their lived experience in their work, drawing on healing, trauma-informed, and recovery-oriented philosophies and ethics that are rooted in the deep history and social justice of the consumer movement. We use the acronym 'LE' in graphs and tables to shorten the term 'lived experience'. We also caution that insights, snapshots, case studies (illustrated in textboxes), and qualitative quotes are direct excerpts from survey respondents and have not been edited.

A comprehensive overview on understanding the language related to lived experience and lived experience (peer) roles is available in *Pathways for Supporting the 'Not Negotiable' Lived Experience (Peer) Workforces to Thrive*[9]*,* particularly pages 12-19.

[9] Hodges, E., Solonsch, L. & Boniface, S. (2022). Pathways for Supporting the 'Not Negotiable' Lived Experience (Peer) Workforces to Thrive: A Scoping Paper for Formal Lived Experience Expertise Training Programs and Supports. Prepared by LELAN (SA Lived Experience Leadership & Advocacy Network) for the National Mental Health Consumer and Carer Forum and the National PHN Mental Health Lived Experience Engagement Network. Mental Health Australia, Canberra.

2 DETAILED RESULTS OF THE LIVED EXPERIENCE STOCKTAKE SURVEY FOR PHN COMMISSIONED PROVIDERS 2024:

2.1 Survey Provider Details

Number of respondents

20 providers completed the stocktake survey. Providers from Queensland, Victoria, New South Wales and Tasmania were represented by respondents. No providers responded from Western Australia, South Australia or the Northern Territory Table 1 shows the Commissioned Service Providers who responded to the 2024 survey.

Table 3. List of Commissioned Service Providers Who Responded to Survey

• Headspace Warrnambool (VIC)	• **QuIHN (NSW)**
• ConnectedLE (QLD)	• Richmond Futures (TAS)
• Headspace Ballarat (VIC)	• Lives Lived Well (QLD)
• Mental Health Council of Tasmania (TAS)	• Baptcare (TAS)
• Change Futures Ltd (QLD)	• EACH (VIC)
• Neami National QLD)	• Queensland Council for LGBTI Health (QLD)
• Mindfulness Programs Australasia (TAS)	• Peach Tree (QLD)
• Step Psychology Pty Ltd (NSW)	• Applied Recovery Co Pty Ltd (Clean Slate Clinic)
• Beacon Strategies (QLD)	• QuIHN
• The Salvation Army, Alcohol and Other Drugs Program (TAS)	• Uniting - headspace Early Psychosis, Western Sydney Cluster (NSW)

Role of person completing survey

The survey suggested manager level positions with access to all necessary data would be appropriate to complete. Roles held by Providers who responded to the survey are shown in Table 4.

Table 4. Role Position of Commissioned Service Provider

• Family & Friends Peer Worker/Navigator	• **State Manager**
• Client Engagement/Peer Engagement	• CEO
• Senior Mental Health Peer Practitioner	• Director
• Lived Experience Advisor	• General Manager Operation
• Lived and Living Experience Lead	• General Manager Human Resource
• Mental Health Team Leader	• Service Manager Lived Exp & Service Manager
• Program Coordinator	• Senior Program Manager Therapeutic Services
• Managing Director/Owner	

2.2 PHN Commissioned Service Providers

Funding and services

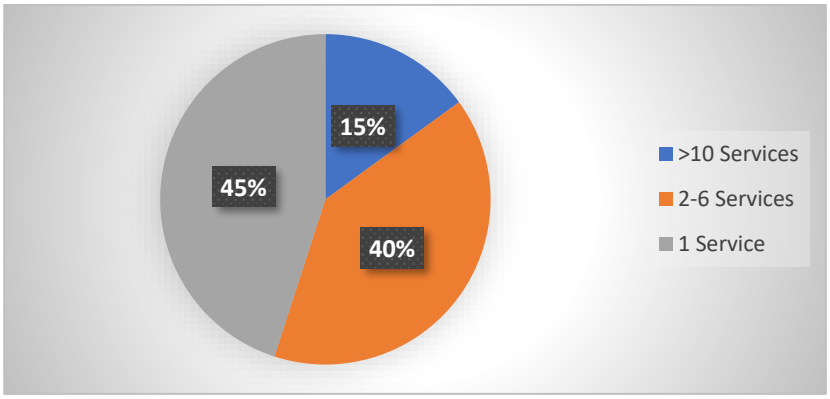
Table 5 shows the PHNs from which providers received funding for mental health services and programs. 85% (n=17) PHNs funded one or more of the 20 providers. One PHN funded 40% (n=8) of providers, two PHNs funded 30% of providers. This was followed by one PHN who funded 20% (n=4) of providers, two PHNs who funded 10% (2 each) and seven PHNs who funded the remaining 5% (1 each).

Table 5. Number of Commissioned Service Providers by PHN Funder

PHN Funder	No of Recipients	PHN Funder	No of Recipients
Brisbane North	8	Western Victoria	2
Brisbane South	6	Murray	1
Tasmania	6	Northern Sydney	1
Country to Coast QLD	4	North Western Melbourne	1
Darling Downs and West Moreton	3	South Eastern Melbourne	1
Gold Coast	3	South Western Sydney	1
Nepean Blue Mountains	3	Went West Western Sydney	1
Central & Eastern Sydney	3	Western NSW	1
Western QLD	2		

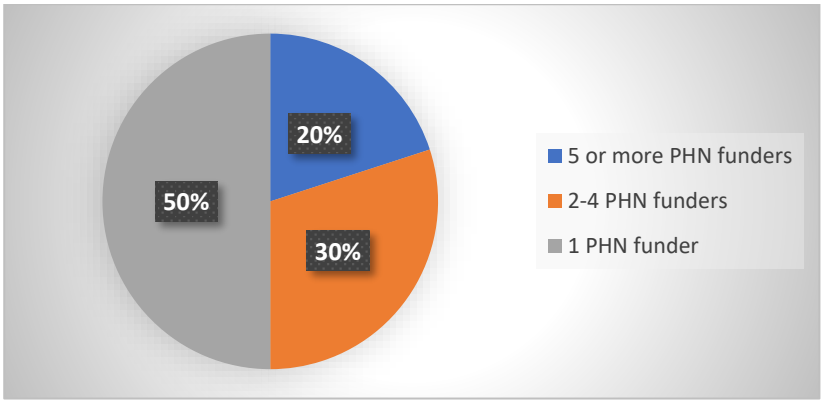
Graph 1 shows the number of commissioned services delivered by providers. 45% (n=9) of providers delivered one service. 40% (n=8) delivered between two to six services, while 15% (n=3) of providers delivered 10 or more funded services.

Graph 1. Number of Commissioned Sercices Delivered by Provider



Providers may receive funding from more than one PHN for one or more mental health and wellbeing service or program. Graph 2 shows the number of PHN in which the providers receive funds. 20% (n=4) of providers received funding from 5 or more PHNs. 30% (n=6) of providers received funding from between 2 and 4 PHNs and 50% (n=10) of providers received funding from 1 PHN.

Graph 2. Number of PHN Funders Per Provider



The number of PHN funders against each Provider Providers is shown in Table 6. As examples, the highest number of programs reported included:

- Provider P delivers fifteen services and programs and receives funding from six PHNs
- Provider G delivers twelve services and programs and receives funding from eleven PHNs
- Provider N delivers ten services and receives funding from ten PHNs.

Table 6. Number of Services Provider Against Number of PHN Funders

Provider (deidentified)	No of Services Provided	No of PHN Funder/s
A	5	3
B	1	1
C	1	1
D	3	1
E	1	1
F	6	3
G	12	11
H	1	1
I	1	1
J	1	1
K	1	5
L	4	2
M	2	1
N	10	10
O	1	2
P	15	6
Q	6	2
R	2	3
S	1	3
T	4	4

Type of commissioned service delivered

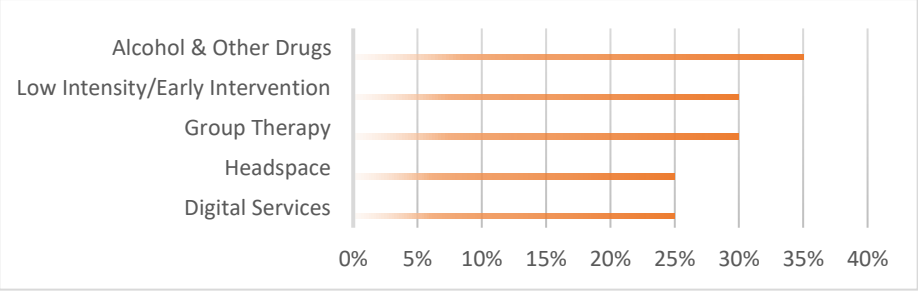
Table 8 shows the type of commissioned services being delivered and the number of providers delivering them.

Table 7. Type of Commissioned Mental Health and Wellbeing Services

Service Type	No Providers Delivering	Service Type	No Providers Delivering
Headspace	(25%, 5)	Low Intensity/Early Intervention	(30%, 6)
Psychological Therapies (Hard to Reach)	(20%, 4)	Group Therapy	(30%, 6)
Head to Health	(5%, 1)	Clinical Care Coordination	(15%, 3)
Youth Severe	(20%,4)	Community Campaigns	(15%, 3)
Safe Spaces	(5%, 1)	Child Youth Specific Programs	
Suicide Prevention – Indigenous	(5%, 1)	Initial Assessment and Referral	(15%, 3)
Suicide Prevention – General	(20%, 4)	Older/Aged Specific Programs	(20%, 4)
Alcohol and Other Drugs	(35%, 7)	Aboriginal Torres Strait Islander Specific	(15%, 3)
Way Back Support Service	(10%, 2)	LGBTQIA+ Specific	(10%, 2)
Early Psychosis Youth	(15%, 3)	Culturally and Linguistically Diverse Specific	(5%, 1)
Telehealth/Online Services	(25%, 5)	Mental Health and Wellbeing Training Services	(15%, 3)
Outreach Programs	(20%, 4)		

Graph 3 shows the most frequently commissioned mental health services delivered by the providers within this cohort, which include 35% (n=7) alcohol and other drugs services, 30% (n=6) low intensity/early intervention services, 30% (n=6) group therapy, 25% (n=5) Headspace and 25% (n=5) digital services including telehealth and online services.

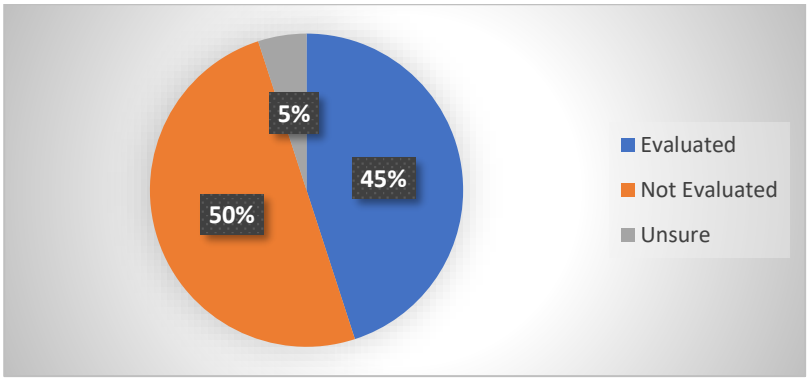
Graph 3. Most Frequently Commissioned Services by Type



Evaluation of commissioned services

Graph 4 shows the number of providers who have evaluated their services. 45& (n=9) of providers have evaluated their services and programs a mandated requirement by their funding bodies or as routine practice, internal to their organisation.

Graph 4. Percentage of Commissioned Services Evaluated



Providers evaluated these services and programs, commented that:

- *We have a Lived Experience advisory friends (LEAF) who provide LE governance for end to end advisory for video-based production of courses. Evaluation was undertaken as part of submission to the National Safety and Quality Commission when applying for accreditation to the National Digital Mental Health Standards (NDMHS) awarded May 2024.*
- *Ongoing as part of current contract — will seek to explore experiences and initial outcomes reported from perspective of people involved in suicide prevention Lived Experienced workforce development activities.*
- *Feedback through consumer advisory group. Data collection on engagement on services involving LE workers.*
- *The Sunshine Parenting Program is a 6-week content led program for mums in the perinatal period. This is our key program and has undergone a comprehensive evaluation process.*

Providers did not evaluate their services and programs, commented that:

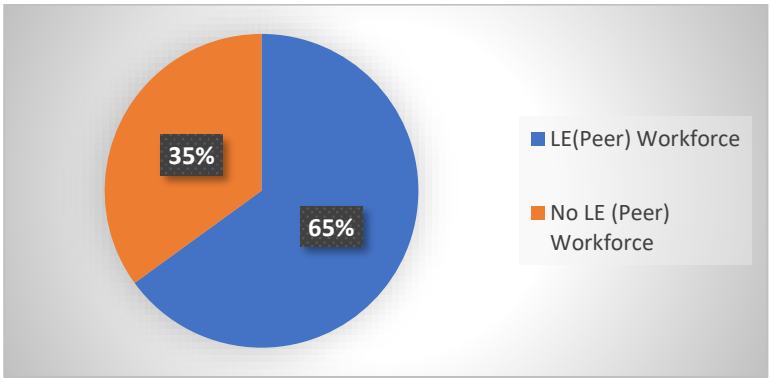
- *It is not a requirement of the contract.*
- *We only have one Lived Experience (Peer)Worker and are looking to expand this in the future and implement evaluation strategies.*

2.3 Lived Experience (Peer) Workforce and Lived Experience, Consumer and Carer Representatives

General statistics for lived experience (peer) workforce

In total, a total of 226 people were employed in designated lived experience (peer) roles. 65% (n=13) of providers were employers of Lived Experience (Peer) Workforces, while 35% (n=7) were not, as illustrated in Graph 5.

Graph 5. Percentage of Commissioned Service Providers with Lived Experience (Peer) Workforces



Of these, notable statistics included the following:

- The highest number of people employed in a designated lived experience (peer) role by a single provider was 100. This provider receives funding from 11 PHNs and is responsible for 12 mental health and wellbeing services and programs.
- Two other providers each employ over 30 lived experience (peer) workforce members – one funded by six PHNs to deliver 16 programs and services, and the other funded by three PHNs to deliver two programs. Eight providers employed under 10 lived experience (peer) workforce members, ranging from 1 to 8 employees, whereas seven providers did not employ any lived experience (peer) roles in their services and programs.

Role type, classification and salary ranges for lived experience (peer) workforce

People with lived experience were employed in both direct and indirect service delivery roles, ranging from one-to-one and group-based roles, to management, executive leadership and governance roles. Other outstanding roles captured in the survey, included lived experience (peer) roles and consumer and carer representative roles in areas related to education and training, auditing, research, consultancy and participation in panels and advisory groups. These roles contribute to mental health policy, service design, and systemic advocacy and reform.

Variation exists across the levels of classification and salary ranges for lived experience (peer) workforces. Direct service staff salary per annum ranged from <$50 000 to $71 000 - $80 000.

As an example, one provider employing the highest number of Lived Experience (Peer) Workforces outlined the following salary ranges across the roles they employ:

- Direct Service Peer Workers Level 3 - $71 000 - $80 000.

- Support Leads Level 5 $91 000 – $100 000.
- Managers Level 6 $101 000 - $110 000.
- Practice Leads Level 7 >$111 000.

Similarly, one provider employing multiple Lived Experience (Peer) Workforce staff across direct service delivery to manager roles outlined salary ranges as:

- Direct service delivery $61 000 - $70 000.
- Coordinator positions $ 91 000 - $100 000.
- Manager positions $91 000 - $100 000.

This provider is currently working on standardises classification levels.

Table 8 summarises lived experience (peer) workforces employed by providers, detailing the number of staff, position titles, classification levels (based on SCHADS), full-time equivalent (FTE) levels and salary ranges.

Table 8. Details of Lived Experience (Peer) Workforce Employees

Provider	No of PLE	Position Title	Classification SCHADS	FTE	Salary range /pa
1	100	Lived Experience Peer Workers (multiple)	Level 3	1.0	$71 000-$80 000
		Peer Support Leads (multiple)	Level 5	1.0	$91 000 – $100 000
		Lived Experience Service Managers (multiple)	Level 6	1.0	$101 000 - $110 000
		Peer Practice Leads (multiple)	Level 7	1.0	>$111 000
2	34	Peer Support Workers	Not provided	0.6	<$50 000
		Lived Experience Team Leaders		0.6	Range from $51 000 - $70 000
		Service Coordinators		0.8	
		Program Development Officer		0.5	
		Program Support Officers		0.6	
		Training Coordinators		0.8	
		Program Coordinator		0.6	Range from $81 000 - $100 000
		Training Managers		0.8	
		Engagement Officer		Not listed	
3	33	LLE Lead / National Practice Lead-Peer Workforce /Peer Cadet Lead (combined roles)	Working on standardised classifications across all roles	1.0	Direct service delivery $61 000 - $70 000 Coordinator positions $ 91 000 - $100 000 Manager positions $91 000 - $100 000
		AOD Peer Workers		2.0	
		Peer Workers		12.6	
		Carer Peer Workers		1.5	
		Senior Peer Worker		0.8	
		Youth Peer Workers		Not listed	
		Family Violence Peer Workers		1.6	
		Cadets		1.8	
		Lived Experience Educators (x3)		2.0	
4	13	Lived Experience Advisor	Not provided	1.0	$91 000 - $100 000
		Lived Experience Coordinator	Not provided	0.8	$81 000 - $90 000
		Lived Experience Peer Worker (digital)	All Peer Worker positions between Levels 3.1 and 3.3	0.8	Between $71 000 - $80 000
		Lived Experience Peer Worker (perinatal)		0.6	
		Lived Experience Peer Worker (AOD) (x2)		0.6 x2	
		Lived Experience Peer Worker (Youth)		0.8	
		Lived Experience Peer Worker (Youth and LGBTQUIAP+)		0.6	
		Lived Experience Peer Worker (Carer) (x2)		0.6 x1 0.8 x1	
		Lived Experience Peer Worker (EP) (x2)		0.4 x2	
5	12	Harm Reduction Workers	Level 5	0.21	$71 000 - $80 000
		Client Engagement Worker	Level 5	0.21	$71 000 - $80 000
		Admin Worker	Level 5	0.21	$71 000 - $80 000
		Harm Reduction Coordinator	Level 6	0.21	$81 000 - $90 000
6	8	Youth Peer Worker (x5)	Aligned with Health Professionals Award (non-clinical)	0.6	$61 000 - $70 000
		Family Peer Worker (x2)		1.0	$61 000 - $70 000
		Peer Coordinator		0.8	$71 000 - $80 000
7	6	Client Engagement Officer	Level 5	1.0	$71 000 - $100 000
		Peer Worker	Level 4	1.0	$61 000 - $80 000
		AOD Peer Worker	Level 4	1.0	
8	5	Mental Health Team Leader	Level 4	1.0	>$100 000
		Mental Health Practitioner	Level 3	1.0	$81 000 - $90 000
		Mental Health Capacity Support Officer (x2)	Level 3	0.4 x2	$81 000 - $90 000
9	5	Intake & Client Support Coordinator	Not aligned to SCHADS	1.0 x4 1xcasual	$91 000 - $100 000
		Head of Innovation & Improvement			
		Financial Controller			
10	4	Lived Experience Peer Worker	Level 4	0.3	$71 000 - $80 000
		Lived Experience Peer Educator	Level 4	0.3	$71 000 - $80 000
11	3	Mental Health Peer Practitioners (x2)	Level 5.2	0.5 x2	$51 000 - $60 000
		Senior Mental Health Peer Practitioner	Level 6.3	0.6	$61 000 - $70 000
12	2	Family and Carer Peer Navigator	Level 3	0.5	<$50 000
		Youth Peer Support Worker	Level 3	0.5	<$50 000
13	1	Family and Friend Peer Worker	Level 3	0.8	$51 000 - $60 000

Service types for lived experience (peer) workforce

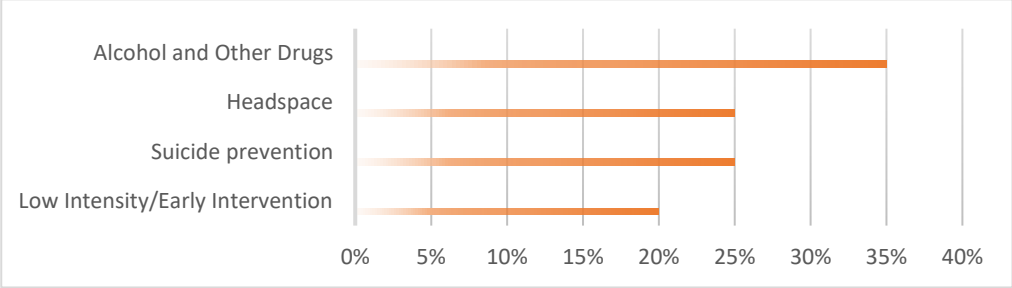
Table 9 and Graph 6 demonstrate the varied commissioned service types that employ people with lived experience in designated roles across the PHNs that responded to the survey.

Table 9. Varied Commissioned Service Types Employing Lived Experience

Service Type	No Providers LE Workers	Service Type	No Providers LE Workers
Headspace	(25%, 5)	Low Intensity/Early Intervention Services	4
Psychological Therapies (Hard to Reach)	(15%, 3)	Group Therapy	(15%, 3)
Head to Health	(5%, 1)	Clinical Care Coordination	(10%, 2)
Youth Severe	(10%, 2)	Community Campaigns	(15%, 3)
Safe Spaces	(5%, 1)	Child Youth Specific Programs	(5%, 1)
Suicide Prevention – Indigenous	(5%, 1)	Initial Assessment and Referral	(10%, 2)
Suicide Prevention – General	(25%, 5)	Older/Aged Specific Programs	(5%, 1)
Alcohol and Other Drugs	(35%, 7)	Aboriginal Torres Strait Islander	(5%, 1)
Way Back Support Service	(5%, 1)	LGBTQIA+	(5%, 1)
Early Psychosis Youth	(5%, 1)	Culturally and Linguistically Diverse	(5%, 1)
Telehealth/Online Services	(5%, 1)		

Most prevalently, 35% (n=7) of providers employed people with lived experience in the Alcohol and Other Drugs setting. This was followed by headspace and suicide prevention settings, accounting for 25% (n=5) of providers, and low-intensity and early intervention settings (20%, n=4).

Graph 6. Service Types Most Frequently Employing Lived Experience



People with lived experience were also employed in designated roles across trauma programs, peer-led programs, Mindset Horizons and Foundations programs and psychosocial supports and group activities.

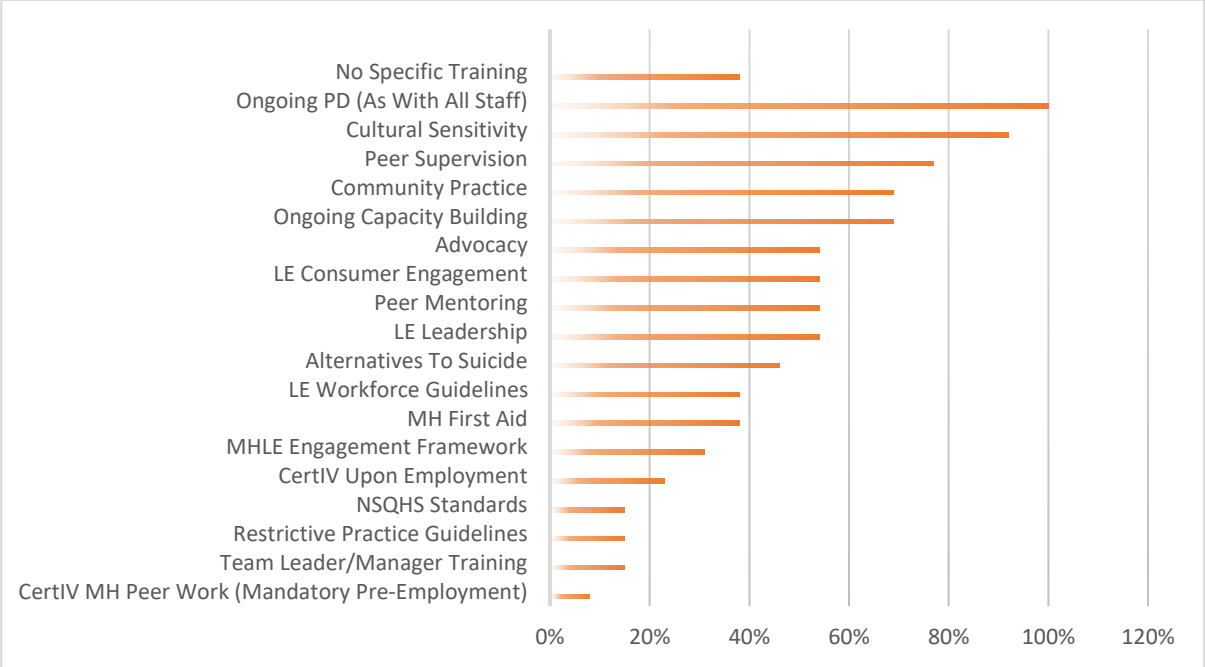
Examples are provided below to demonstrate the varied commissioned service types that people with lived experience work within, as designated members in lived experience (peer) workforces.

- One provider employed people with lived experience across nine services including psychological therapies, Head-to-Health, Safe Spaces, Suicide prevention-general, Way Back support service, community campaigns, Initial assessment and referral, Aboriginal and Torres Strait Islander specific services, Culturally and Linguistically Diverse specific services.
- One provider employed people with lived experience across eight services including youth severe, alcohol and other drugs, low intensity/early intervention, group therapy, community campaigns.
- One provider employed people with lived experience across seven including suicide prevention – indigenous, suicide prevention – general, Low intensity/early intervention, group therapy, child and youth specific programs, older/aged specific programs.

Professional development, training and education for lived experience (peer) workforce

All providers offer access to ongoing professional development, training and education opportunities for all staff employed. Graph 7 demonstrates training specifically provided to people with lived experience internal and external to the organisation, whereas Graph 8 demonstrates lived experience (peer)-driven professional development opportunities for the designated workforce.

Graph 7. Training Offered to Lived Experience (Peer) Workforces by Commissioned Service Providers

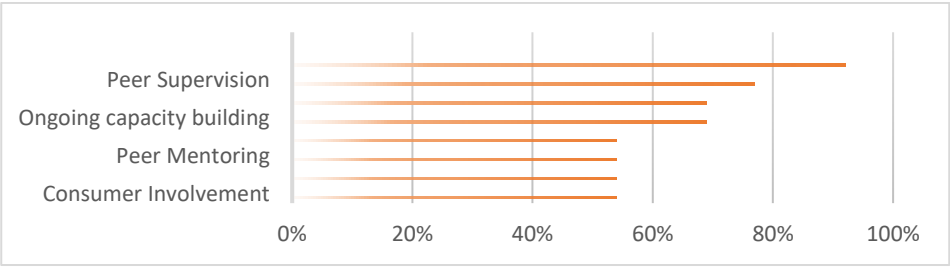


The most frequently provided training included Cultural Sensitivity Training, with 92% (n=12) of providers offering this to people with lived experience in designated roles. This was followed by Peer Supervision (77%, n= 10), Community Practice for Peer Workers (69%, n=9) and ongoing capacity building.

Other non-lived experience (peer)-based training offered to people in designated roles included Mental Health First Aid Training, NSQHS Standards, as well as leadership development training.

The Certificate IV in Mental Health Peer Work was considered a standard among providers, although only one provider reporting this as a mandatory pre-employment requirement. 23% (n=4) of providers provided Peer Workforce Training Program (including the Cert IV) as an option upon employment.

Graph 8. Most Frequently Provided Training for Lived Experience (Peer) Workforce - Lived Experience Specific



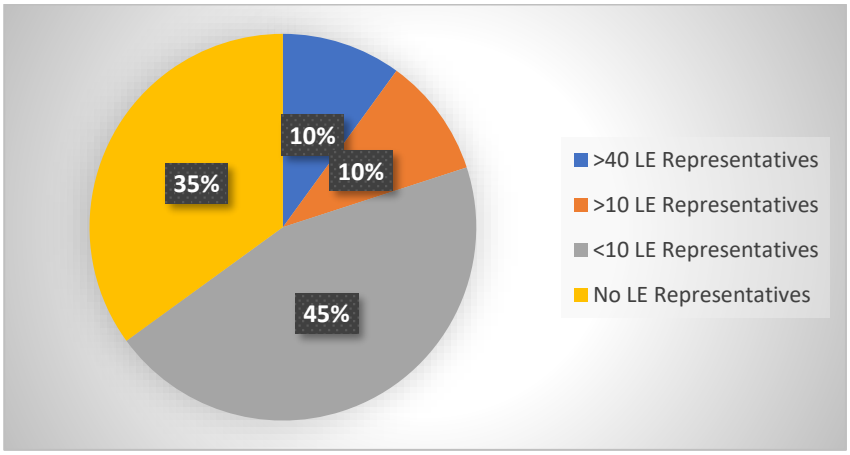
General statistics for lived experience, consumer and carer representatives

In total, 215 people with lived experience were engaged in Lived Experience, Consumer and/or Carer Representative roles by providers. Graph 9 shows the number of Consumer and/or Carer Representatives engaged by providers.

Of these, notable statistics included:

- 67% (n=13) of providers currently engaged Lived Experience, Consumer and/or Carer Representatives, while the remaining 35% (n=7) do not have Consumer and/or Carer Representatives engaged across their portfolios.
- 35% (n=7) of providers did not have Lived Experience, Consumer and/or Carer Representatives integrated into their governance structures, while 20% (n=4) of providers neither employed or engaged these representatives in the planning, delivery, or evaluation of their commissioned mental health services or programs.
- The highest number of representatives engaged by a single provider was 50.

Graph 9. Number of Lived Experience Representatives engaged by Commissioned Service Providers



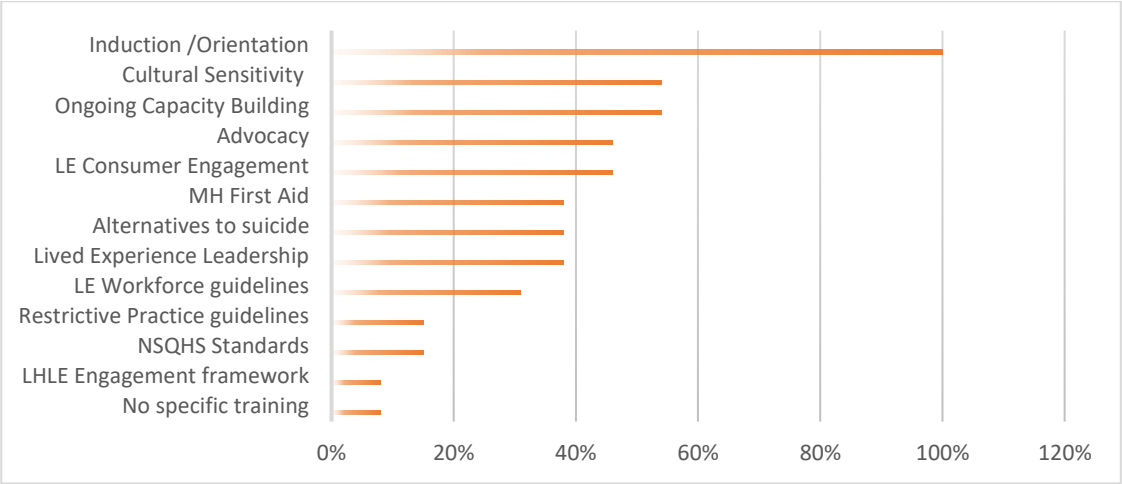
Professional development, training and education for lived experience, consumer and carer representatives

All providers provided an induction and orientation program for Lived Experience, Consumer and/or Carer Representatives. Graph 10 summarises other training offered to Lived Experience, Consumer and/or Carer Representatives once engaged or employed by a provider.

Like Lived Experience (Peer) Workforces, the most frequently provided training included Cultural Sensitivity Training with 54% (n=7) of providers offering this training. This was followed by 46% (n=6) of providers offering engagement and advocacy training, and 38% (n=5) of providers offering Mental Health First Aid, Alternative to Suicide Training, and Lived Experience Leadership Training, respectively.

Only one provider did not provide specific training for Lived Experience, Consumer and/or Carer Representatives.

Graph 10. Training Provided to Lived Experience Representatives by Commissioned Service Providers



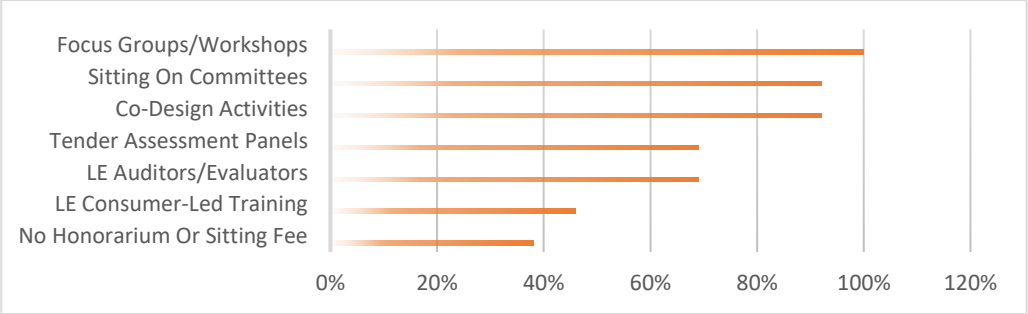
Honorarium or sitting fee for lived experience, consumer and carer representatives

In total, 67% (n=13) of providers paid Lived Experience, Consumers and/or Carer Representatives for participating in activities such. 38% (n=5) of providers did not pay their representatives a sitting fee or honorarium for any engagement activity. The rationales provided were based on the premise of engagement activities being framed as survey responses, or in cases where providers drew on lived experience panels from other parts of the organisation, which were accounted in different budget lines or on existing lived experience groups, networks, and collectives external to the organisation.

Graph 11 provides a further breakdown of the activities in which representatives were paid for the lived expertise and advice.

Of the 13 providers, all paid for their representatives to be a part of focus groups and workshops. This was followed by 92% (n=12) providers paying for their representatives to sit on committees and participate in co-design activities. 69% (n=9) paid and engaged representatives in audits, evaluations and tender assessment panels, while 46 (n=6) paid and engaged representatives to deliver lived experience (peer)-ed training, specific to consumers.

Graph 11. Types of Paid Lived Experience Activities



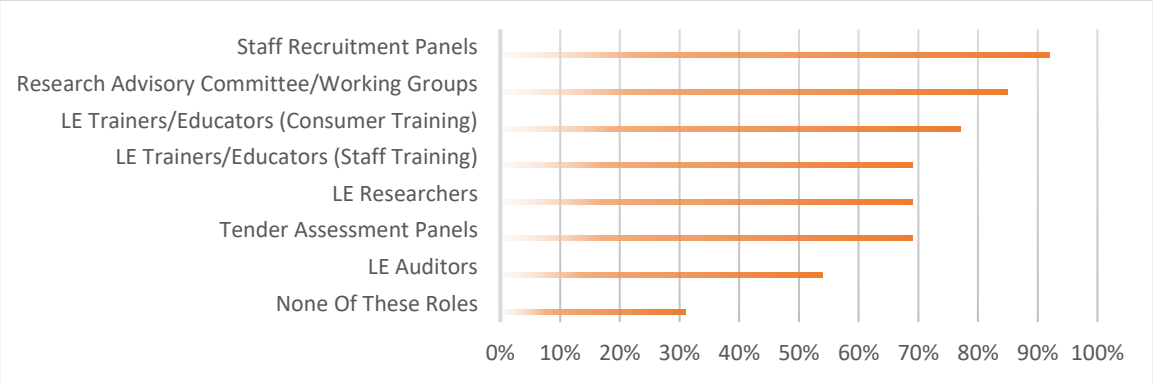
Additional Roles

Graph 12 demonstrates that Lived Experience (Peer) Workforces and Lived Experience, Consumer and/or Carer Representatives take on additional roles, outside of providing their Lived Expertise and Advice to organisations. 92% (n=12) of providers have included people with lived experience on staff recruitment

panels, while 85% (n=11) involved representatives on Research Advisory Committees/Working Groups. 77% (n=10) were engaged and paid in speaker, trainer or educator roles (specific to consumers).

31% (n=4) did not engage people with lived experience in any of these additional roles.

Graph 12. Additional Lived Experience (Peer) Workforce Roles



SNAPSHOT: Provider - Lived Experience (Peer) Workforce

The Provider employs 100 Lived Experience staff.

The Service Provider receives funding from 11 PHNs and provides 12 programs and services. They employ Lived Experience staff in 9 of the 12 programs. The services and programs they deliver include psychological therapies, Head to Head, safe spaces, suicide prevention-general, Way Back support service, community campaigns, Initial assessment and referral, Aboriginal and Torres Strait Islander specific Services, Culturally and Linguistically Diverse specific services.

Lived Experience staff are employed in this program across the follow positions, classifications, salary range and reporting relationship:

- Lived Experience Peer Workers (Level 3) $71 000-$80 000– reporting to Peer Support Leads
- Peer Support Leads (Level 5) $91 000 – $101 000– reporting to Lived Experience Service Managers
- Lived Experience Service Managers (Level 6) $101 000 - $110 000– reporting to Peer Practice Leads
- Peer Practice Leads (Level 7) >$111 000 - reports to Senior Manager Operations

Their Lived Experience staff, in additional to the professional development as available to all staff, have access to the following education and professional development training:

- Lived Experience/Consumer Engagement /Advocacy
- Cultural sensitivity
- Alternative to suicide
- Lived Experience Leadership
- Peer Supervision
- Peer mentoring
- Community practice for peer workers
- Mental health Lived Experience engagement frameworks/guidelines
- Lived Experience workforce guidelines
- Ongoing capacity building training

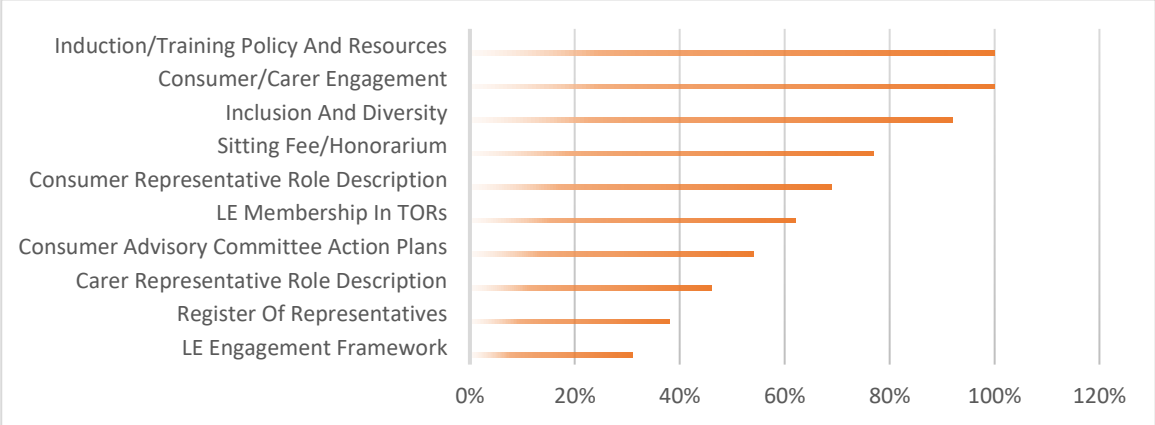
2.4 Integration of Lived Experience Engagement

Graph 13 shows policies and procedures implemented by providers in the context of lived experience engagement. As mentioned in the previous section, all providers implemented some form of induction, orientation and training, as per foundational policies guiding the operationalisation of Lived Experience (Peer) Workforces and Lived Experience, Consumer and/or Carer Representatives.

92% (n=12) of providers have integrated Lived Experience into their Inclusion and Diversity Policy and related processes across their organisation.

77% (n=10) have a Sitting Fee/Honorarium Policy for engaging with Lived Experience, Consumer and Carer Representatives. 69% (n=9) of providers have related role descriptions for consumer representatives, while 62% (n=8) for carer representatives. 46% (n=6) have developed membership expectations, responsibilities, as well as Terms of Reference for people with lived experience engaged in these roles.

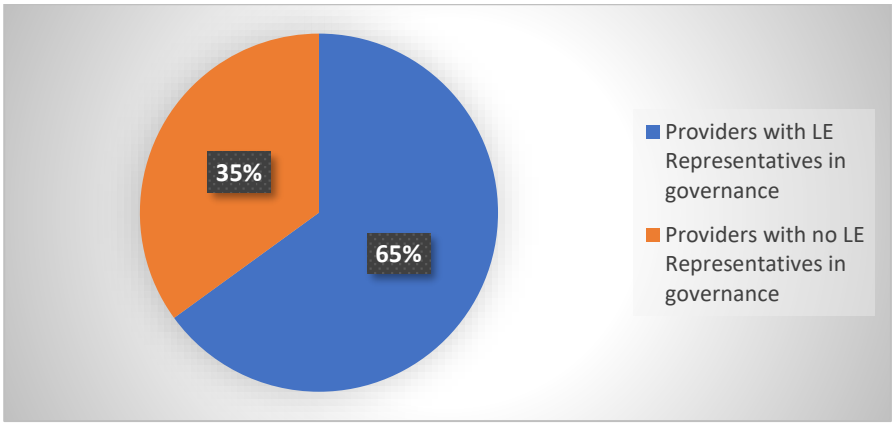
Graph 13. Lived Experience Policies and Procedures Developed by PHNs



Lived experience, consumer and/or carer representative partners in governance

In summary, 65% (n=13) of providers have engaged Lived Experience, Consumer and/or Carer Representatives in governance and management structures, while the remaining 35% (n=7) providers have not. The most significant barrier was identified as resource allocation and funding. Other barriers are included challenges with developing related action plans, policies and processes, position statements, as well as operational and logistical considerations, such as travel costs for people with lived experience in remote locations.

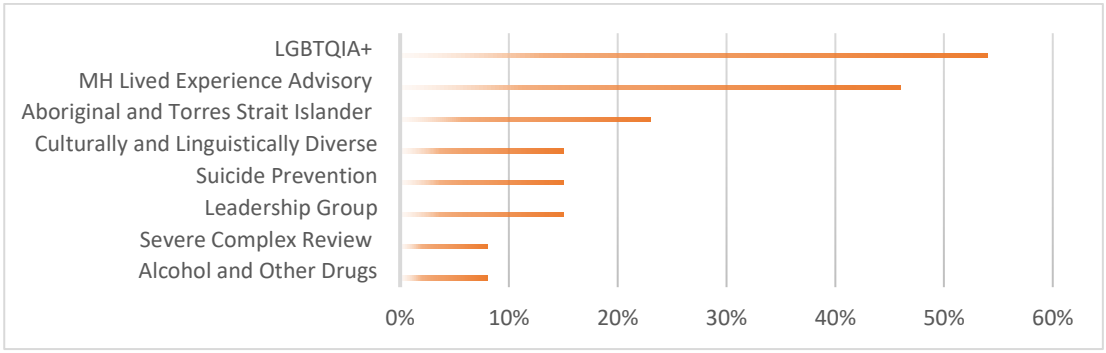
Graph 14. Percentage of Providers with Lived Experience Representation in Provider Governance Structures



Lived experience representatives on committees

Graph 15 shows the different committees and reference groups with lived experience (peer) representation. This included reference groups for specific priority groups, including LGBTQIA+, Aboriginal and Torres Strait Islander people, and Culturally and Linguistically Diverse groups and communities.

Graph 15. Percentage of Providers with Lived Experience Representation in Committees or Membership Groups



SNAPSHOT Provider – Lived Experience, Consumer and Carer Representatives

The Service Provider engages with a total of 50 Lived Experience Consumer or Carer Representatives.

The organisation has policies and procedures that support the engagement of people with Lived Experience including Consumer/Carer Engagement policies and procedures, Induction/training program materials, Sitting fee/honorarium policy and procedures, Lived Experience membership/responsibilities in committee terms of references and a Consumer Advisory Committee action plan.

Representatives receive induction and orientation to the service and the role. They also are provided with training that includes Cultural Sensitivity; Lived Experience Leadership; Mental Health First Aid; Lived Experience Workforce Guidelines and Working Effectively on Committees.

Lived Experience Consumer and Carer Representatives receive a sitting fee or honorarium for engagement activities including sitting on committees; participating in codesign activities; providing Lived Experience Consumer Led training programs; participating as Lived Experience Representatives in audits and evaluation and participating in a range of other involvement and engagement activities (eg focus groups, workshops). The Service provider pays Representatives for all activities they participate in.

In addition to engagement activities, Consumer and Carer Representatives and Lived Experience (Peer) Workforce staff and take on extended roles including Lived Experience speakers, trainers, educators (providing training for both staff and consumers); Lived Experience researchers/evaluators; Lived Experience internal auditors/reviewer; members on tender assessment panels; members of Research Advisory Committees and Working Groups and staff recruitment panels.

Lived Experience Representatives sit on a number of Advisory Committees including Aboriginal and Torres Strait Islander Advisory Committee, Alcohol and Other Drugs Committee, LGBTQIA+ Advisory

Strategies to engage with priority groups

55% (n=11) of providers identified specific strategies implemented to engage with different priority groups. Examples are provided in the following qualitative excerpts.

- *We approach, listen to what they need or request and ensure that matches with our offerings and codesign programs from this or refer on if we are unable to meet the need.*
- *We have priority communities' reference and advisory group with Lived Experience (Peer) Workers and/or Lived Experience Consumer or Carer Representatives as part of the committee membership.*
- *We approach peak Lived Experience organisations, send out expressions of Interest and circulate consumer opportunities on their website.*
- *We engage with [priority] reference groups when co-designing groups. This often involves working with key organisations to support engagement and safety. For example, our suicide prevention module we worked closely with Roses in the Ocean - a Lived Experience of suicide organisation. For the eating disorders and social media course we worked closely with the Butterfly Foundation. In all cases we work with the key people and organisations through the co-design and co-creation of the courses through every step including approval for release of course material and videos.*
- *We utilise social media to access a broad spectrum of LGBTIQ Sistergirl and Brotherboy folk. Engaging directly without service users of the QC mental health team to seek feedback, suggestions and options for participation. Engagement and, where possible, collaboration with key community groups e.g. MGOV.*

- *We develop tailored engagement plans and strategies for each community / group that we are seeking to support. We apply our general values of 'inclusiveness' and 'meeting people where they are at' with good practice principles of genuine co-design with the communities we serve.*

Diversity and inclusion

55% (n=11) of providers shared how they reflected the diversity and intersectionality of people with lived experience in their engagement activities. 45% (n=9) of providers felt that their organisation had established a Lived Experience (Peer) Workforce and related engagement strategies, while 10% (n=2) felt integrated a designated workforce, as a requirement of their PHN funding, enhanced diversity and inclusion broadly across their organisation.

Qualitative excepts related to Diversity and Inclusion are documented below:

- *Yes so much so that based on our Lived Experience participant engagement we have included modules on diversity and inclusion within our training packages for school teachers and university residential colleges.*
- *Yes, we have moved from just having a youth peer worker to now a family and carer peer worker who engages with other staff and project.*
- *We pride ourselves on our diversity and inclusion approaches with policies, roles and strategies embedded within everything we do.*
- *We approach each service from depending on the needs of the local area and community. The employment and engagement of people from diverse experiences and backgrounds is prioritised and matched to the service need.*
- *We intersect with each group for each course as they are all different, rather than have one person or set of people that might not represent the different groups we work with*
- *We are always striving to have a diverse and inclusive workforce which reflects the communities where we service. We consistently engaged in specialist LE experts on a range of topics.*
- *We are an 100% peer-led organisation. All peer groups, social inclusion groups and parent education programs facilitated by peer workers with a Lived Experience of mental health challenges in the perinatal period. We continuously strive for diversity within the workforce.*
- *I think we are a leading example of employing Lived Experience roles, in that our Lived Experience workers are truly integrated into the team and are represented across every aspect of the business, including:*
    - *Our CEO brings Lived Experience.*
    - *Our Financial Controller is a past participant of our program.*
    - *Our Client Experience Lead is a past participant of our program.*
    - *3 Members of our Leadership Team are Lived Experience.*
    - *The majority of our Onboarding Team are Lived Experience.*
    - *The majority of our Smart Recovery Facilitators are Lived Experience.*

(30%, 6) Providers provided case examples of engaging with priority groups.

Case Study: Aboriginal and Torres Strait Islander Stress, Anxiety and Depression Course

Provider has funding to offer 4 week courses for adults who live with or are at risk of stress, anxiety and depression and we offer these specifically to indigenous organisations as closed groups, so only access by people who are invited by the organisation.

These courses are devised in collaboration with key staff and timings, duration and course content are negotiated prior to course commencement and run at the location of the organisation.

Due to the small nature of the organisation, the diverse groups they work with across Tasmania and tight funding, they collaborate with each organisation or group they work with rather than have access to constant people with Lived Experience.

Case Study: Aboriginal and Torres Strait Islander Home Detox Services

Since discussions began in November 2022, The Provider, in partnership with Western Queensland PHN, has made considerable progress in delivering home-based detox services to First Nations communities within the region. Working closely with the Nukal Murra Alliance and Goondir Health Services, the clinic has crafted care pathways that are culturally responsive and aligned with community needs. This partnership, formalised in July 2024, is reinforced by regular virtual meetings and face-to-face visits, fostering stronger connections with Goondir clinicians, clients, and other community leaders.

Key achievements include developing a "no wrong door" referral process, ensuring that Goondir clients can access services with ease, as well as refining treatment plans and resources to suit the diverse linguistic and literacy needs of the population. Additionally, the provision of harm minimisation tools like breathalysers and thiamine has addressed both logistical and financial barriers, allowing clients to begin making informed choices about their alcohol use immediately.

Looking forward, the nurse and community corrections worker's forthcoming co-facilitation of Yarn Smart groups will bring culturally tailored addiction support to the region, with the potential for expanding this model to broader community justice initiatives. The collaboration continues to evolve, emphasising culturally appropriate care, improved access, and ongoing community engagement to ensure the best possible outcomes for First Nations individuals in Western Queensland.

Case Study: Trans, Gender Diverse and Non-Binary Community Day of Healing

In 2023 members of the trans, gender diverse and non-binary (TGDNB) community experienced an unprecedented increase in levels of discrimination and abuse. Many of the Provider's mental health team's service users reported overwhelming trauma symptoms, feelings of safety in public spaces, experiences of agoraphobia, social isolation, direct and indirect discrimination, and marginalisation. The QC Trans Health Promotion Officer and the QC mental health team utilised input and feedback from the community group Many Genders One Voice (MGOV) and put together a Trans Day of Healing in July 2023.

TGDNB community members were invited to share what would make this event safe enough for them to attend and what types of activities folk would like to participate in. This resulted in the organisation of a community event for TGDNB folk to come together for a day of collective healing, connection, empowerment, and celebration. This event offered a place of care to (re)connect with the Provider and each other, and was a joint project between MGOV, Open Doors Youth Service and the Mental Health Team made possible by funding from the Brisbane North PHN.

Based on TGDNB community member's feedback and input from service users of the mental health programs, the event included an array of activities: including a therapeutically guided discussion and sharing (facilitated by LGBTIQ mental health practitioner, A Single Step) art therapy, trauma informed Wing Chun workshops, a drum circle, and a presentation on activism and human rights by the LGBTI Legal Service and Action Ready (a not-for-profit organisation formed by volunteers in Meanjin who believe that educating the community in the law can help ordinary people subvert the system in new and creative ways while making informed, strategic decisions).

2.5 Self-Assessment Integration of Lived Experience

Integration of lived experience self-assessment survey

Table 10 reports self-assessed results relating to the integration of lived experience in their organisation.

Table 10. Integration of Lived Experience Self-Assessment Scores

Statements relating to the **Service/Program**	Not current practice	Developing Practice	Frequent Practice	Routine Practice
We use a standardised codesign approach in developing and reviewing our organisation's services and programs	10%	20%	25%	45%
We have Lived Experience members on service and program steering committees and/or reference groups	15%	40%	10%	55%
We have integrated Lived Experience (Peer) Workers across our organisation's services and programs	25%	15%	20%	40%
We provide Peer Led mental health programs (e.g. Alt2Su)	30%	25%	15%	30%

Statements relating to the **Organisation**	Not current practice	Developing Practice	Frequent Practice	Routine Practice
We have Lived Experience representation on key governance committees outlined in Terms of Reference.	25%	25%	10%	40%
We have an established Consumer Advisory Committee with Lived Experience Representative members	35%	20%	0%	45%
We have established specific advisory committee/reference groups for priority groups with Lived Experience representation	20%	30%	5%	45%
People with Lived Experience participate as speakers/trainers as part of induction and orientation of staff and consumers	30%	15%	20%	35%
We support, promote and commission access to training programs specific to supporting People with Lived Experience	10%	30%	30%	35%
Our Lived Experience roles reflect diversity of our Workforce, service users and the community	20%	15%	15%	50%

Statements relating to **Lived Experience Policy**	Not current practice	Developing Practice	Frequent Practice	Routine Practice
We develop and review policies in codesign with People with Lived Experience	15%	25%	15%	40%
We have developed specific engagement policies and processes in codesign with People with Lived Experience	20%	20%	30%	30%
Our policy reflects, promotes and facilitates diversity and inclusion of People with Lived Experience	5%	30%	30%	35%

Statements relating to **Audit and Evaluation**	Not current practice	Developing Practice	Frequent Practice	Routine Practice
People with Lived Experience participate as internal auditors and reviewers as part of clinical governance	40%	10%	20%	30%
People with Lived Experience participate as internal auditors and reviewers as part of service delivery monitoring and review	30%	5%	15%	40%
People with Lived Experience participate in governance oversight and monitoring	25%	20%	25%	30%
People with Lived Experience participate as partners in research and research evaluation	35%	25%	15%	25%
We audit and review our involvement activities and the level of Lived Experience contributions to ensure best practice	15%	45%	15%	25%
We collaborate with other organisations across other jurisdictions in shared learning to compare and evaluate our practices and strategies and to improve Lived Experience involvement and engagement	20%	30%	25%	25%

TABLE KEY:

Areas of established practice - where the columns Frequent and Routine Practice total 50% or >
Areas for development – where the columns Not Current and Developing Practice total 50% or >
Potential gap areas – where the column Neither Agree not Disagree totals 50% or >

Established areas

Based on self-assessments, the following areas documented were areas where providers had integrated lived experience.

Table 11. Areas in Lived Experience Integration Considered as 'Established'

Area of LE Integration	Established Areas
Service/Program	• Standardised codesign approach across services and programs • Integrated Lived Experience (Peer) Workers across services and programs
Organisation	• People with Lived Experience participate as speakers/trainers as part of induction and orientation of staff and consumers • Access to Lived Experience programs • Lived Experience roles reflect diversity of workforce, service users and the community
Lived Experience Policy	• Develop/review policies in codesign with People with Lived Experience • Specific engagement policies and processes in codesign with People with Lived Experience
Audit and Evaluation	• Lived Experience internal auditors and reviewers in service delivery monitoring and review • Lived Experience partners in governance oversight and monitoring

Areas for development

Based on self-assessments, the following areas documented were areas for development relating to lived experience integration.

Table 12. Areas of Lived Experience Integration Considered as 'Developing Areas'

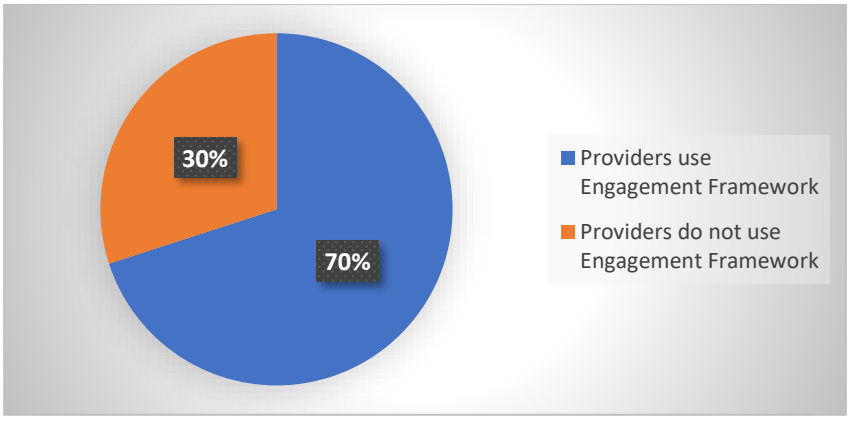
Area of LE Integration	Areas for Development
Service/Program	• Lived Experience members on service and program steering committees and/or reference groups • Peer Led mental health programs (e.g. Alt2Su)
Organisation	• Consumer Advisory Committee with Lived Experience Representative members • Lived Experience representation on advisory committee/reference groups for priority groups
Lived Experience Policy	• Policy reflects, promotes and facilitates diversity and inclusion of People with Lived Experience
Audit and Evaluation	• Lived Experience internal auditors and reviewers as part of clinical governance • Lived Experience partners in research and research evaluation • Audit engagement activities and Lived Experience contribution to ensure best practice • Collaboration with other organisations shared learning to improve Lived Experience involvement and engagement

2.6 Engagement Framework

Use of engagement frameworks

As illustrated in Graph 16, 70% (n=14) of providers relied on an engagement framework to integrate strategies and actions for involving and partnering with People with Lived Experience. While 30% (n=6) of providers did not.

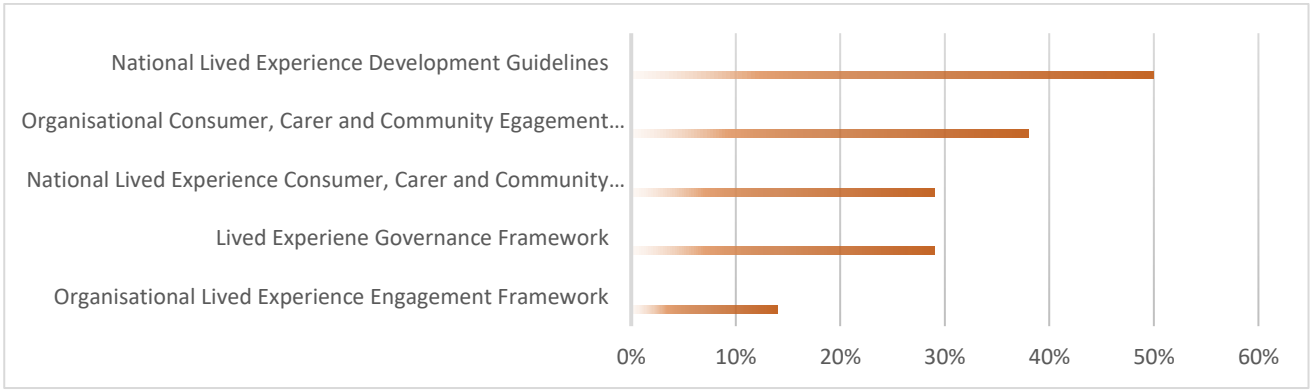
Graph 16. Percentage of Providers Using an Engagement Framework



Type of engagement framework

Graph 17 shows the type of engagement framework providers used guide their integration of lived experience, with some providers stating in qualitative responses that that internal engagement frameworks were under development.

Graph 17. Type of Engagement Used by Commissioned Service Providers



One Provider outlined their use of routine feedback both formally and informally across service delivery aspects and then regular review and refinement of processes etc in accordance and others stated their engagement framework was currently under development. Another identified that they use Lived Experience (Peer) Workforce and community engagement sessions initiated statewide by their CEO and senior leadership team, feedback via direct contact and social media, service user satisfaction surveys.

Example:

- *We are Lived Experience led and have Lived Experience team members throughout our organisation, so we always lead with the client experience. We tailor our approaches to any specific projects we may be developing, for example, in Western Queensland we have developed a strong relationship with Goondir Health, which has been underpinned by frequent visits to the community and implementing the 5Cs of Collaboration.*

Collaborative lived experience engagement activities

70% (n=14) of providers took a more collaborative approach to their lived experience engagement activities, connecting in with other relevant local, state, national and/or international stakeholders.

From qualitative responses, providers identified many stakeholders engaged in the context of lived experience engagement. Examples are provided below.

- *Co-designed with key organisations and people including Roses in the Ocean, Butterfly Foundation, Red Frogs, Drug and Alcohol Research Australia (DARTA), iCAN, Dr Dinesh Palipana, UQ Respect, Royal Flying Doctors Service (RFDS). A number of PHNs for example Western Qld PHN and WentWest supported engagement with Lived Experience participants including Aboriginal and Torres Strait Islander peoples, refugees and rural communities.*
- *MHCT partnered with Mental Health Family and Friends and Mental Health Lived Experience Tasmania to develop a consultation to understand barriers to accessing mental health services. This included the co-facilitation of workshops with people with Lived Experience.*
- *Current program of work is leading implementation of a Suicide Prevention Lived Experience Workforce Development Initiative in Central and Eastern Sydney together with a guiding coalition of members of the SP LE Workforce, with the key audience for activities that the Coalition determines being the wider SP LE workforce in that region. The 'plan' of activities and flexible funding is designed and overseen by the Coalition.*
- *QC and Open Doors formed part of a collective with a range of key LGBTIQ organisations across Queensland and across different parts of the LGBTIQ community (e.g. Indigilez, Rainbow Families) in order to deliver the National Suicide Prevention Program.*

Lived experience engagement reporting measures

65% (n=14) of providers monitor and measure the effectiveness of their lived experience engagement strategies. 35% (n=7) of providers did not gather this relevant data, with some unsure of what data to collect and its relevancy to the organisation. One provider, in particular, shared that lived experience perspectives were foundational to what they did but were unsure on how to report on it.

50% (n=10) of providers were in the early processes of developing data and feedback mechanisms. These included data collection methods (e.g., surveys, questionnaires and self-report mechanisms), standards of measurement and key performance indicators, as well as record keeping related to lived experience engagement activities (e.g., meeting minutes).

Three providers outlined examples in the context of reporting. An example is provided in the following excerpts:

- *We measure our impact on clients, including: - How many clients complete our patient experience strategy - Client's experience of care and whether the felt in control of their care and that it is tailored to them - Net Promoter Score. We also measure staff engagement and satisfaction*

annually, including whether our Lived Experience staff feel empowered and able to do their job. We are confident that the organisation is living up to its values. We do not specifically measure Lived Experience Engagement effectiveness.

- *Quantitative data of self-efficacy, index of wellbeing, and impact of engagement. Qualitative experiences should involve participation action approach that gathers views and perspectives that enable ongoing improvement. Ensure data moves beyond medical model to person-centred approach where views and perspectives are captures. Research also captures a preventative approach to connect people to the right support at the right time.*

Providers were largely unsure of how to measure and report on their lived experience engagement activities and were open and honest about their lack of knowledge and skills in this area. Qualitative data responses gave rise to discussions relating to standard outcome areas, areas of improvement and evidence of organisational change. MHLEEN'S stocktake surveys, as well as other regular standards that are yet to be developed, were identified as external methods to ensure that data was reported and monitored regularly for continuous improvement.

2.7 Levels of Involvement

Levels of involvement among providers

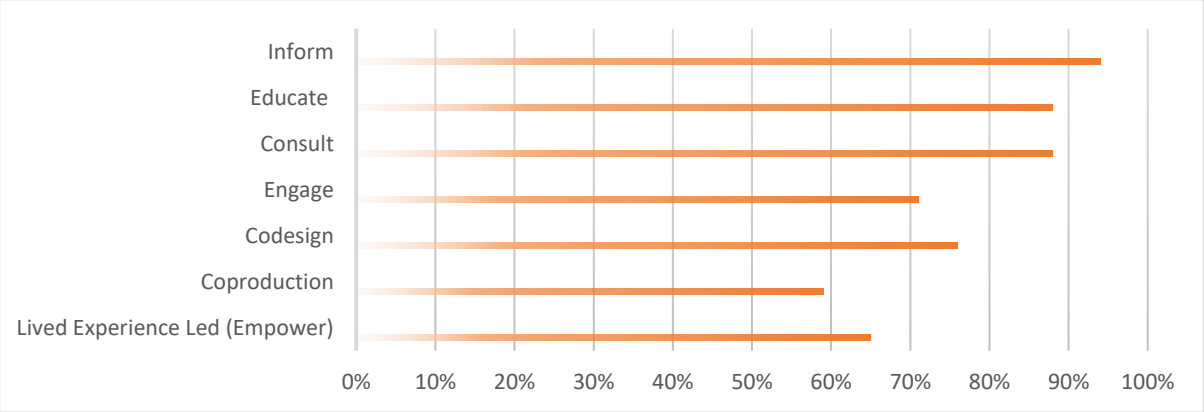
Of the total 20 providers, 65% (n=14), who involved people with lived experience, reported on varying levels of involvement across a seven-point spectrum[10]. Of these 14 providers, 47%, (n=8) reported on all seven levels of involvement.

18 (n=3) of providers primarily use strategies in at the Inform, Educate, and Consult levels, as well as delivering lived experience (peer)-led services and/or programs.

18% (n=3) of providers currently use one level of involvement and in process of expanding their level of involvement, developing strategies, processes and structures to aid in these endeavours.

15% (n=3) of providers provided a 'Not Applicable (N/A)' response or did not respond to related questions around levels of lived experience involvement. Graph 18 shows the percentage of providers who use each of the seven levels of Involvement.

Graph 18. Percentage of Commissioned Service Providers with Lived Experience Involvement Across Levels of Involvement



In what follows, we report further detail relating to each of the seven levels of involvement.

INFORM: provision of information to people with lived experience to support decision-making

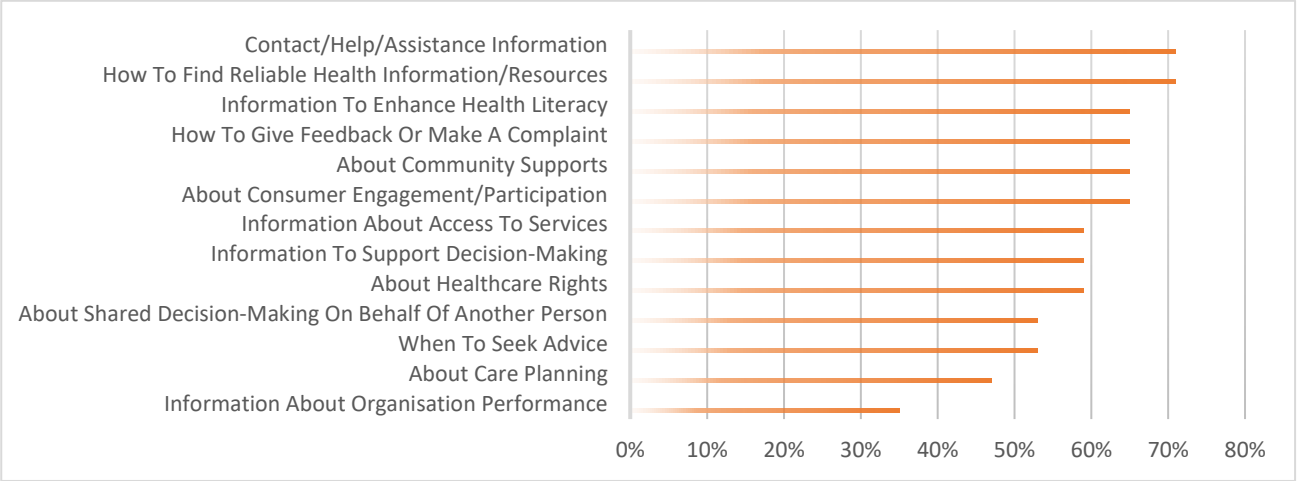
Graph 19 shows the range of strategies providers implemented to inform people with lived experience with relevant information to support decision-making. Of these, notable statistics included:

- 71% (n=12) of providers informed people with lived experience on how to find reliable information. Similarly, 71% (n=12) of providers focused on providing contact, help and assistance information.
- 65% (n=11) of providers focused on enhancing health literacy. The same number of providers focused on information relating to feedback and complaints mechanisms, community-based support options, and lived experience engagement activities.

[10] This seven-point spectrum identifies increasing levels of involvement. These levels include Inform, Educate, Consult, Engage, Co-Design, Co-Production, and Lived Experience Led/Empower. This spectrum is based on an adaptation of the IAP2 Levels of Public Participation to align more closely with the National Mental Health Commission's Consumer and Carer Engagement Guide.

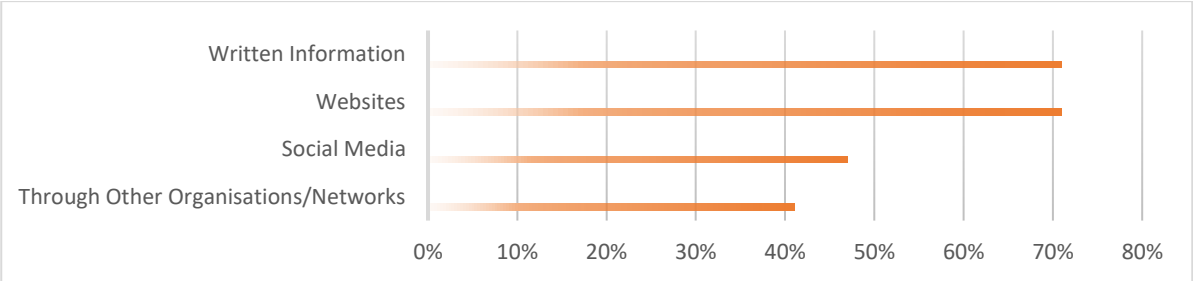
- Strategies related to decision-making and choice in the context of individual care were less prevalent, with 53% (n=9) of providers providing information related to shared decision-making, making decisions on behalf of someone else, or when to seek additional advice and care planning.

Graph 19. Type of Information Provided to People with Lived Experience by Commissioned Service Providers



Graph 20 demonstrates the modalities in which information was provided to people with lived experience. This included written information, online via websites and social media presences, as well as through other organisations and networks.

Graph 20. Provider Strategies to Inform

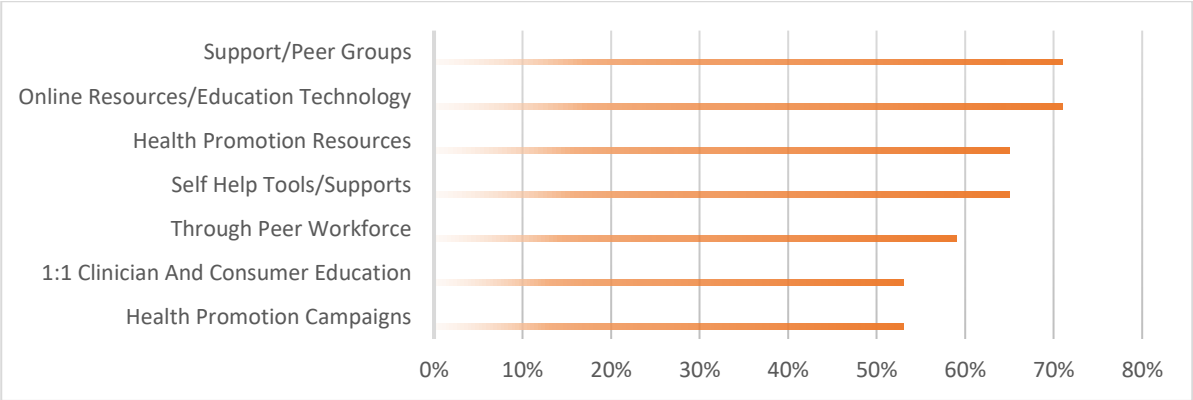


EDUCATE: education for people with lived experience to understand problems, alternatives, and solutions

Graph 22 shows the range of educational strategies used by providers. Of these, notable statistics included:

- 71% (n=12) of providers educated people with lived experience through support/peer groups, and online and technology-based resources, respectively.
- 65% (n=11) of providers used health promotions resources, or self-help tools and supports, respectively.
- 59% (n=10) of providers educated through lived experience (peer) workforces in one-on-one settings.
- 53% (n=9) provided one-on-one clinician to consumer education or used health promotion campaigns.

Graph 21. Provider Strategies to Educate

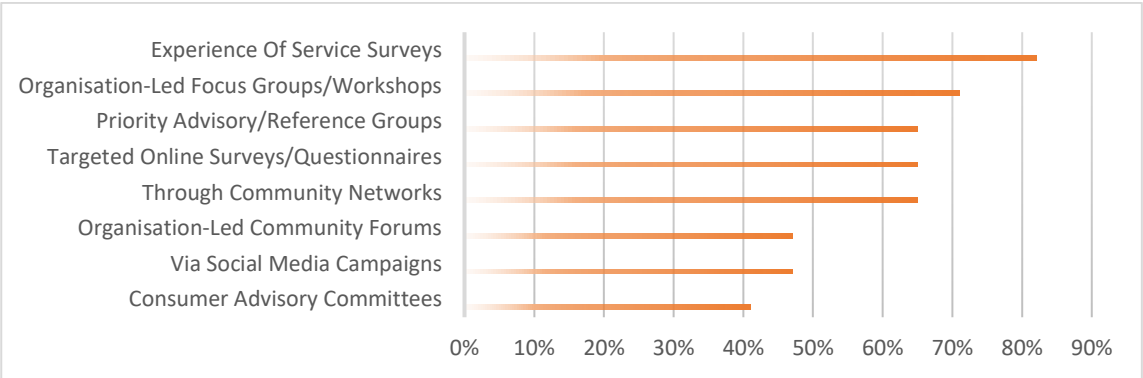


CONSULT: seek feedback from people with lived experience for purposes of decision-making, service design and delivery, planning, governance and evaluation

Graph 22 shows the range of strategies providers implemented to consult with people with lived experience for varied purposes. Of these, notable statistics included:

- 82% (n=14) of providers consulted through service experience surveys. This was followed by focus groups and workshops, (71%, n=12). Group-specific advisory committees or reference groups, targeted online surveys and questionnaires, and community groups/networks accounted for the remaining strategies, used by 65% (n=11) of providers respectively.
- Consumer Advisory Committees were critical as a governance structure, to provide lived experience-based feedback at the governance level. However, these committees were used by 41% (n=7) providers.
- One provider had Lived Experience (Peer) Workforces represented in their leadership team.

Graph 22. Provider Strategies to Consult

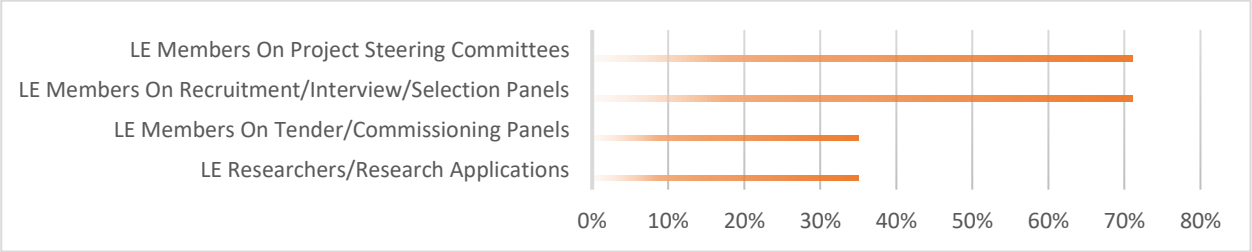


ENGAGE: work with people with lived experience to ensure perspectives are considered

Graph 23 shows the range of strategies providers implemented to engage people with lived experience, to ensure their perspectives were thoughtfully considered and shape related organisational decisions and actions. Of these, notable statistics included:

- 71% (n=12) of providers engaged people with lived experience through committees or working groups. Similarly, the same number of providers engaged people with lived experience to sit on recruitment, interview and selection panels.
- 35% (n=6) of providers had people with lived experience on tender and commissioning panels or engaged them as researchers. Those involved as lived experience researchers also assisted oi the preparation of research-related applications and submissions.

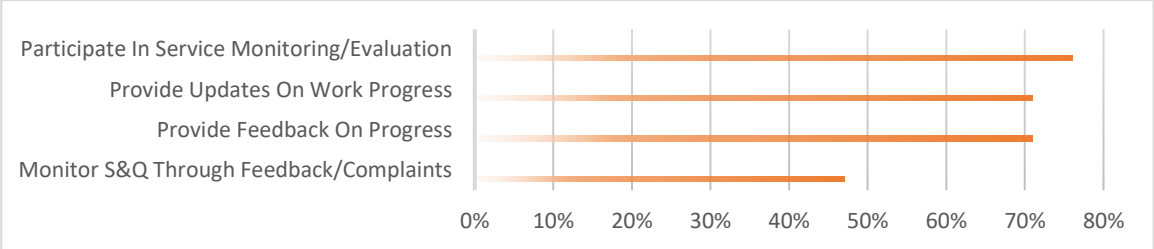
Graph 23. Provider Strategies to Engage



Graph 24 shows the varied purposes of engaging people with lived experience at this level. Of these, notable statistics included:

- 76% (n=13) of providers engaged people with lived experience to provide feedback and commentary on related provider updates, or for service monitoring and evaluation purposes, respectively.
- 71% (n=12) of providers saw the purpose of engagement activities as a means to report back on organisational progress.
- 47% (n=8) reported using lived experience-based feedback and complaints to measure organisational performance.

Graph 24. Providers' Purpose for Engagement

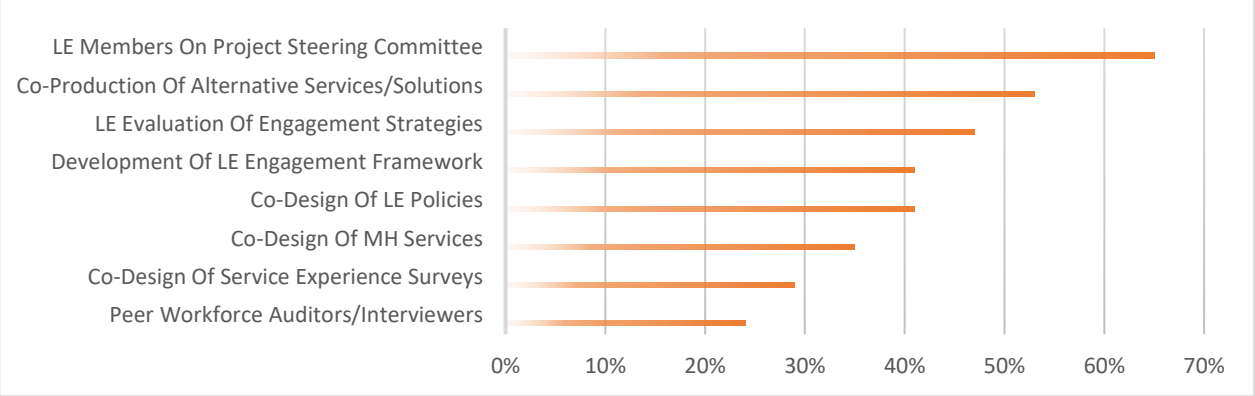


CO-DESIGN and CO-PRODUCTION: partner with people with lived experience to create, implement and evaluate impactful and meaningful solutions, strategies, services and systems

Graph 25 shows the range of strategies and type of co-design work where providers partner with people with lived experience. Of these, notable statistics included:

- 76% (n=12) of providers identified co-design and co-production strategies as means to partner with lived experience.
- Co-design and co-production strategies were implemented less frequently compared to other strategies on the seven-point spectrum. For example, only 25% (n=5) or providers co-design and co-produced consumer experience surveys with people with lived experience.
- 65% (n=11) of providers co-designed with people with lived experience in the format of project steering committees.
- 53% (n=9) of providers co-designated alternative options and solutions for services and programs, while 41% (n=7) of providers partnered with lived experience to co-design lived experience-specific engagement frameworks.

Graph 25. Providers' Purpose for Co-Design and Co-Production

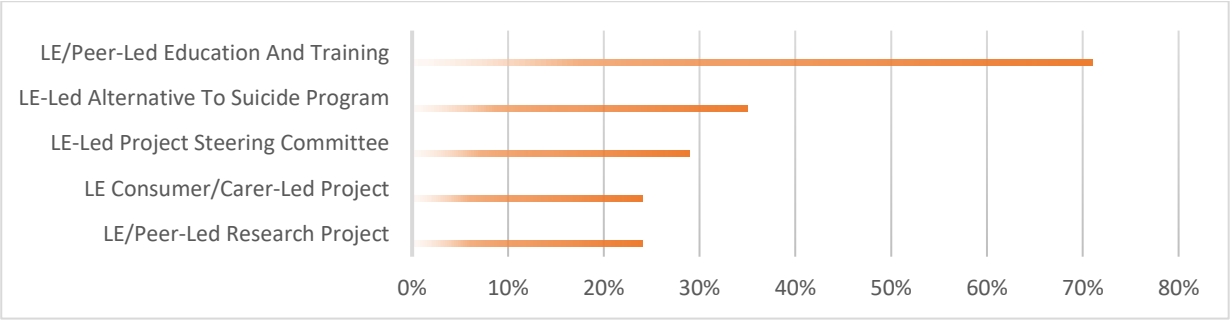


LIVED EXPERIENCE-LED/EMPOWER: people with lived experience lead and are in control of decision making and related solutions, strategies, services and systems

Graph 26 shows the range of lived experience-led activities as identified by providers in their operational contexts. Of these, notable statistics included:

- 71% (n=12) of providers implemented lived experience (peer)-led education and training for their workforces and consumers in their organisations.
- 35% (n=6) of providers have delivered lived experience (peer)-led programs, such as suicide prevention programs.
- 29% (n=5) have implemented lived experience-led project steering communities, while 24% (n=4) have co-led lived experience projects initiated by lived experience advisory committees for consumers and carers.
- 24% (n=4) have conducted lived experience (peer)-led research with consumers.

Graph 26. Lived Experience-Led Activities



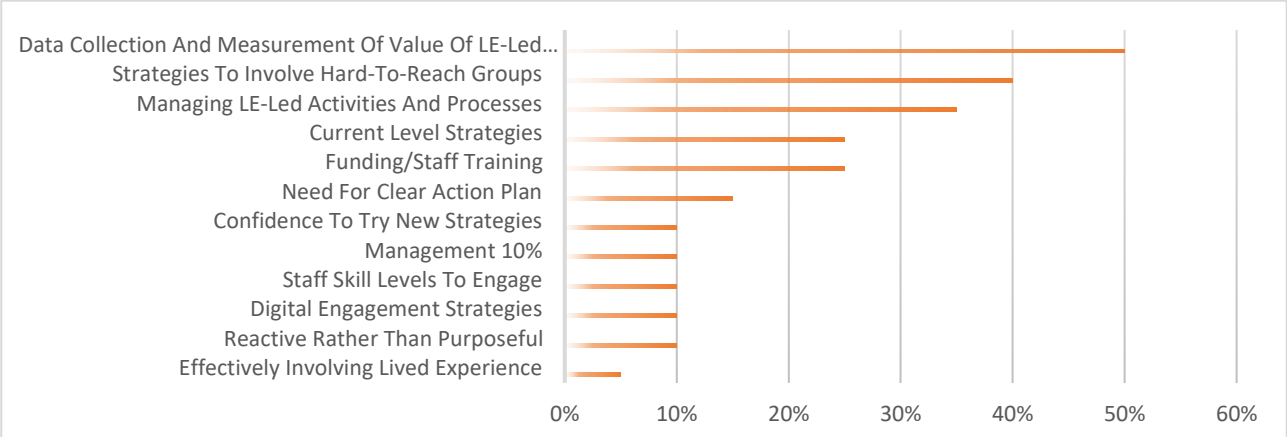
Challenges to increased lived experience involvement

Graph 27 reports challenges experienced by providers in their attempts to integrate lived experience involvement across their organisations. Consistent with previous statistics in the Engagement Section, Challenges were mostly related to data collection and providers' abilities to measure the value of lived experience involvement, with 50% (n=10) of providers reporting being challenged by this.

Other notable challenges included:

- Identification of effective strategies for involving hard-to-reach target groups was reported by 40% (n=8) of providers.
- Management of involvement activities and processes, such as planning, resources, and coordination was reported by 35% (n=7) of providers.
- Resource allocation for workforce development and training to involve and partner with lived experience was reported by 25% (n=5) of providers. Similarly, the same number of providers were challenged by the level, range, and scope of current involvement strategies, suggesting that the knowledge and skillsets were lacking.
- Confidence in trying new and innovative strategies, organisational commitment, the skills and experience of senior staff and management, the need for digital engagement strategies, and the implementation of reactive or tokenistic co-design—rather than purposeful involvement—were also identified as barriers by 10% (n=2) of providers, respectively.
- Standards or definitions of what constitutes good practice were also recognised as a barrier by one provider, accounting for 5% of providers.

Graph 27. Challenges to Lived Experience Integration



2.8 Levels of Involvement Case Studies

Thirteen case studies were submitted by 45% (n=9) of providers. Five providers contributed two case studies each, while the remaining four providers submitted one each. Providers were asked to contribute case studies from the highest two levels of involvement.

Educate Case Studies

One case study was submitted to this level of involvement. This case study focused on 'toolbox' information sessions, conducted both in-person and online, covering topics of interest to LGBTIQ community members.

Case Study

Title	**Psychosocial Toolbox Sessions**
Level	Educate
Staff	1 staff member (Lived Experience), 6+ external facilitators (community members or recognised LGBTIQ allies), 50+ external participants.
Activities	The worker responsible for the QC psychosocial program in 2023 organised a series of "toolbox" information sessions, both in person and online, that covered a range of topics LGBTIQ community members had expressed an interest in learning more about.
Learnings	Partnering with other organisations (both LGBTIQ specific and mainstream) to provide information sessions tailored to members of the LGBTIQ community enabled us to present on a diverse array of topics whilst also ensuring safety and inclusion of all participants.
Challenges	Challenges around engaging with LGBTIQ community members who are not already linked with QC services.

Engage Case Studies

Three case studies were submitted, including:

1. An internal lived experience survey assessing organisational maturity in areas such as lived experience (peer) work knowledge, recruitment and training, barriers to workforce growth, supporting infrastructure, and lived experience (peer) workforce experiences.
2. Development of resources to explain a new model of care.
3. Effective engagement strategies with multicultural families and carers.

Case Study

Title	**Lived and Living Experience survey for all MHAOD staff**
Level	Engage
Staff	The survey was completed by 13 peer workers, 9 managers, 12 team leaders and 55 other team members. This is approximately 25% of our MHAOD workforce. The survey branched depending on what role the staff member identified themselves as being in. The purpose of the survey was to assess how mature the organisation is in the LE space. The LLE lead wrote a report on the survey results, comparing and contrasting responses of various staffing groups, under the following headings: 1. Level of understanding of peer work 2. Recruitment and training of peer workers 3. Barriers to growth of peer workforce 4. Supportive factors 5. Peer worker experiences
Activities	The survey was based upon a DOH LE survey from 2023. The LLE Leadership team, Service Design and the Director of MHAOD worked to create a survey relevant to our organisation. Then we worked with the Data team to place the survey on Snap Forms. We had several staff from the LE Working Group volunteer to road test the survey. After the survey was run, the LLE Lead worked with the Data team to create a report on Power BI.
Learnings	Organisational readiness training needs to be provided to all MHAOD staff to increase the level of understanding of and appreciation for LLE work roles
Challenges	It would have been good to have more staff complete the survey, however there are so many workplace surveys staff get a bit weary of them. The survey was meant to run on an annual basis, however the Director-MHAOD has now decided that it would be best to run it every two years in order to reduce survey fatigue but also to give time for the effects of organisational readiness training to be noticeable.

Case Study

Title	**Explaining models of care**
Level	Engage
Staff	2 Peer Workers Staff Participants
Activities	Development of resources and ways to explain some of the contentious issues around the new model of care
Learnings	Peer explanations work better
Challenges	Educating the peers to address concerns and manage potential conflicts

Case Study

Title	**CMY 'Meet us at the table'**
Level	Engage
Staff	Center for multicultural youth staff Youth worker
Activities	Mental health parent presentation
Learnings	How to effectively engage with multicultural family and carers
Challenges	Gaining a suitable time for everyone to meet

Co-Design and Co-Production Case Studies

Two case studies were submitted, including:

1. The Trans Day of Healing event, developed in response to feedback from an LGBTIQ+ reference group.
2. A co-designed Healthy Ageing and Wellbeing Course, created in response to mental health training needs identified by the specific team, with input from older people and staff working with them.

Case Study

Title	**Trans Day of Healing**
Level	Co-Design
Staff	5 Lived Experience mental health clinicians (QC), all workshops and activities presented by community members and Representatives of LGBTIQ organisations (7 people), Many Genders One Voice community group (3 people) and Lived Experience community members who assisted with running the event (5 people - reimbursed for their participation). 50+ external participants.
Activities	Feedback from Many Genders One Voice as the reference group and co-facilitators of the event throughout the process of organising the event. Engagement with QC mental health service users to gather suggestions about activities and feedback around proposed plan for the day. Liaising with external Providers of events to ensure wherever possible the facilitator they provided for their activity was a member of the target community.
Learnings	This process worked well however we would like to strengthen and formalise the process of engaging community members in the planning and implementation of the event, along with stronger feedback mechanisms.
Challenges	Given the trauma experienced by many of the target community members, folk are sometimes reticent about being involved, becoming overcommitted, or feeling as though their access to services could be jeopardised if they were unable to attend or unable to participate in planning and feedback.

Case Study

Title	**Healthy Ageing Essentials for Mental Wellbeing Course**
Level	Co-Design
Staff	17 people involved. Two internal staff who project managed the whole co-design and co-creation process of course including engagement with Lived Experience participants. Five Lived Experience participants who were engaged in the co-design of course (reference group), provided their perspectives through video-based interviews, reviewed content in post-production and provided approvals for inclusion in the course. Four PHN staff involved in the connection of key Lived Experience participants and review of learning objectives and overall course outcomes. Two clinical advisors who also participated in interviews and post-production process. Two Health Education advisors engaged to review course material and video content for approval. Two video-production crew who filmed and worked with team during co-production process.
Activities	Worked with Western Qld PHN healthy ageing team who identified need for mental health training that had greater input from older people, and those working with them. Co-design workshop was held with a group of older people (with Lived Experience of mental health challenges) to determine priority areas to explore in training. Another co-design workshop held with the advisory team at the PHN to further refine learning objectives and key training outcomes. Health Education Advisory group at ConnectedLE engaged to conduct research to understand human-centred design questions to ask during interview with Lived Experience participants. This group were also involved in the research and development of key resources within the ConnectedLE platform. Questions were checked and validated with Lived Experience group of older people. Clinicians (Geriatrician and specialist OT who works in aged care sector) engaged in care governance process to support quality and safety process. Production team filmed, edited and worked with ConectedLE directors to create the course videos and embed within the platform.
Learnings	Lived Experience participation across all co-design, co-production and co-creation is essential if want authentic Lived Experience perspectives to come through in the storytelling. Insights are invaluable and why course are valued and have reported high completion rates.

Challenges	Process of engagement can be time consuming - but essential investment in relational expression required to support genuine Lived Experience participation.

Two case studies were submitted to this level, including:

1. Development of a suicide prevention action plan in collaboration with a Lived Experience (Peer) Workforce Coalition.
2. Co-production of mental health service design and delivery by a leadership team with people with lived experience represented.

Case Study

	Suicide Prevention Lived Experience Workforce Development Initiative
Level	Co-Production
Staff	1 LE Lead Facilitator in project team 10 x members of a Lived Experience Workforce Coalition
Activities	Program is ongoing but have so far undertaken EOI to form a guiding coalition, undertaken initial orientation and collective forming of terms of reference, initial identification of key context/strategic environment/ideas through surveys and 1:1 conversations. Next steps are to bring together a wider group of members of the Suicide Prevention Lived Experience workforce development in the region to collectively develop an 'action plan', then we will support the Coalition to prioritise and allocate resourcing to these activities where our role will be to coordinate, communicate and evaluate these activities in partnership with the Coalition over the next ~12 months
Learnings	Still in initial phases of longer-term piece of work, but early learnings are around time required to form relationships and building shared understanding of a program's drivers/context.
Challenges	Managing competing priorities/commitments for people to have time and space to engage intellectually in work like this, particularly for those highly experienced and capable members of the Lived Experience workforce who are often in high demand and working across multiple programs/projects/roles.

Case Study

Title	**Clean Slate Clinic Leadership Team**
Level	Co-Production
Staff	8 Individuals Participate in Our Leadership Team, which drives all aspects of service design; delivery. 3 of these 8 have Lived Experience of substance dependence themselves, and a further 2 have Lived Experience of a direct family member struggling with substance dependence. CEO (Lived Experience), Senior Government; After Care Lead (Lived Experience), Medical Director, Lead Nurse, Partnerships Lead (Family Lived Experience), Customer Excellence Lead (Lived Experience) Marketing Lead, Chief Operating Officer (Family Lived Experience)
Activities	This group oversees every aspect of Clean Slate's work and ensures Lived Experience is at the heart of everything we do.
Learnings	Lived Experience led is part of our DNA and this has been instrumental in us adopting and continuing to refine an approach that is truly person centred. Just some examples of the things we've identified through this model: - Picked up language issues in our quarterly notes review that may be perceived as stigmatising and had a debate with the full team about when it is appropriate to use the term 'denies' when describing an interaction with a client - Developed webinars with a clinician and Lived Experience lead to talk through a range of issues impacting clients and clinicians, including shame and the use of zero alcohol drinks in recovery - to help build a shared understanding - Outlined our strategic priorities
Challenges	We recognize that whilst we have strong Lived Experience throughout our organisation, that doesn't mean we have the diversity of Lived Experience that the communities we support have, and we therefore need to ensure we undertake specific community engagement activities with communities that sit outside of our shared Lived Experience.

Lived Experience-Led/Empower Case Studies

Five case studies were submitted relating to this level, including:

1. Peer delivery of SMART recovery and psychoeducation groups.
2. Development of a Peer Leadership Framework, in the context of Alcohol and Other Drugs settings.
3. Development of a Lived Experience (LE) Strategy/Work Plan.
4. Peer Navigation Project.
5. SMART Recovery Capacity Building Project.

Case Study

Title	**Peer Led Education Programs**
Level	Lived Experience Led/Empower
Staff	Peer workers x 2 Staff Participants
Activities	Peer delivery of SMART recovery groups, Peer delivery of psycho education groups
Learnings	Participants provided feedback that they learned more, were better engaged and enjoyed groups more, attendance numbers increased
Challenges	Need to pay for peers to be trained facilitators

Case Study

Title	**Develop a Peer Leadership Framework**
Level	Lived Experience Led/Empower
Staff	All staff contributed, but work was led by 2 peer leaders, our peer drug user organisation, management, and other peer leaders and community.
Activities	A comprehensive document developed by people who use drugs / AOD peer workers, peer leaders, community, and partners. Development of a literature review, surveys, consultations across the state, and working group. Work was led by 2 peer workers –lit review, consultations, surveys, and working group was all led by people who use/have used substances, to inform the writing a document that informs how QuIHN will build on and continue to commit to peer leadership as an organisation, and the recommendations about how we do this. I will share the Framework once we have officially launched it internally.
Learnings	This involved all levels, domains and areas of the organisation, and is a significant piece of work.
Challenges	Time and resource intensive, mutually available times, workload

Case Study

Title	**Development of LLE Strategy/Work Plan 2024-2028.**
Level	Lived Experience Led / Empower
Staff	LLE leadership team Director MHAOD Director Ops Enablement Members of the LLE Strategic Advisory Committee.
Activities	The draft LLE Strategy was developed by the LLE Leadership team and Service Design. Feedback received from the Directors of MHOAD and Ops Enablement was incorporated. A LLE Strategic Advisory Committee was set up to advise on the Strategy and monitor work happening under the Strategy. Based on the feedback received from clinical and LLE committee members, the LLE Strategy was finalised, promoted and released onto the intranet
Learnings	It's interesting as we work through the Strategy, hearing from the clinical committee members about how funding or staffing restrictions imposed by funding bodies limit our ability to create a LLE Workforce Target. So in many ways doing this work collaboratively increases everyone's understanding of the underlying issues at play.
Challenges	It can be time consuming getting bodies of work approved under the Strategy. This is due to only having monthly meetings and also when there are differences of opinion to work through.

Case Study

Title	**Peer Navigation**
Level	Lived Experience Led / Empower
Staff	1 Peer Support Worker - Primary responsibility for guiding clients through the outcome measures process, ensuring that surveys are completed at baseline, 1 month, and 3 months. 10 Counsellors/Case Managers, 1 Team Leader, contact centre staff - Collaborate to identify clients who would benefit from additional support in completing outcome measures
Activities	Engagement and communication: The Peer Support Worker engages directly with clients to explain the purpose of the OMs and to offer support and reassurance throughout the process. Regular follow-ups are conducted to remind clients of incomplete surveys and to offer any assistance if they encounter any barriers in completing them Personalised support: The Peer Support worker uses their Lived Experience to provide personalised support to help clients understand the relevance of the OMs in their recovery journey. This also involves offering practical strategies that have worked for the peer support worker in similar situations. Collaborative debriefing: The peer support worker debriefs with clinical staff to share insights from client interactions and to discuss potential adjustments in the approach to better meet clients' needs.
Learnings	We have observed that clients are significantly more engaged in the survey process when they understand the value and importance of the surveys in their recovery journey. The support provided by the LE worker has proven particularly effective in reducing clients' anxiety around participation and increasing overall survey completion rates. Additionally, we have learned that clients greatly appreciate flexible communication options, such as phone calls, face-to-face appointments, emails, and text messages, which allows them to engage with the process in a manner that suits their individual needs and preferences.
Challenges	Survey fatigue - Some clients experience fatigue with the repeated surveys, especially if they don't see immediate relevance to their recovery. Technological barriers - When supporting clients to complete a survey over the phone, there are challenges involved when dealing with poor phone reception. This can lead to calls being cut off or the client's responses becoming unclear, which disrupts the flow of the survey and may require multiple attempts to complete. Comprehension of survey questions - Some clients may struggle with understanding the survey questions, particularly if they have cognitive or language barriers, which can prolong the process and make it more challenging to obtain accurate information. Booking appointments to complete surveys - The peer support worker role is part-time; this can be particularly challenging when a client is eager to begin their treatment immediately but must wait until the peer worker is available to complete a baseline OM with them.

Case Study

Title	**SMART Recovery Capacity Building**
Level	Lived Experience Led/Empower
Staff	20 Counsellor/Case Managers/Treatment Facilitators (20% of which identify as having Lived Experience) 2 Consumers 2 Peer Support Workers
Activities	Lived Experience Led Our Lived Experience workforce secured scholarships to upskill 20 staff in SMART Recovery facilitation across multiple domains. SMART Standard, SMART Yarn, SMART Youth, SMART Family and Friends and SMART Inside and Out. Engage We also secured a club grant which allowed us to support two clients to complete SMART Facilitator training. This has allowed those consumers to give back and continue to engage with other consumers in a meaningful way. Consult The Lived Experience team consulted with Dr Nick Kerswell to ensure the meaningful coverage of SMART facilitation as a part of the broader SMART roll out at Lives Lived Well. Lived Experience staff were responsible for applying for the scholarships and allocating them to ensure good SMART facilitation coverage in NSW. A key finding was that approximately 20% of our SMART Recovery groups are facilitated by staff who identify as having Lived Experience,
Learnings	We have a stronger non identified Lived Experience presence within SMART Facilitation in the organisation than initially thought. Coordinating and registering 22 participants in various trainings which span across 12 months is time consuming and requires ongoing monitoring.
Challenges	No clear challenges other than the logistics of registering 22 participants in separate trainings

2.9 Summary Assessment of Leadership in Embedding Lived Experience

Leadership in embedding lived experience self-assessment

Before presenting the results of this self-assessment (see Table 13 and below), it is important to provide context and clarify the parameters of the data:

- One respondent (5%) strongly disagreed or disagreed with a greater proportion of the statements, representing all responses in the "strongly disagree" category.
- One respondent (5%) selected "neither agree nor disagree" for all statements, accounting for 5% of all responses in this category.

Further observations from the funding and policy responses include the following:

- No respondents self-assessed as "strongly agree."
- A higher proportion of respondents selected a neutral position ("neither agree nor disagree").
- A significant portion of respondents abstained from responding to this section:
    - One respondent (5%) did not respond to any statements.
    - Four respondents (20%) answered fewer than 50% of the statements.
    - Eight respondents (40%) did not respond to the statement regarding the identification of areas for prioritisation of systemic change and professionalism of the Lived Experience (Peer) Workforce in funding, policy, planning, and service commissioning.

The assessment of "strongly disagree" by one respondent suggests that they may perceive these statements as irrelevant or unnecessary for their organisation. The lack of responses in the funding and policy section also likely indicates that these respondents view the statements as not relevant to their organisation and thus selected a neutral position or refrained from answering.

Table 13. Leadership in Embedding Lived Experience Self Assessed Scores

Our organisation promotes a culture of support and allyship to:	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Actively oppose discriminatory language, policies and practice	0	0	0	15%	85%
Actively and vocally support the work of the Lived Experience (Peer) Workforce	0	0	5%	20%	55%
Actively advocate for Lived Experience positions and funding	0	5%	15%	20%	55%
Work collaboratively and respectfully in authentic partnerships	0	0	0	30%	70%
Defer to and step aside to credit Lived Expertise and share power	0	0	25%	10%	55%
Facilitate opportunities for Lived Experience leadership	5%	5%	15%	25%	55%
Seize opportunities to creatively use resources and invest in Lived Experience roles	5%	10%	15%	30%	45%
Advocate for Lived Experience roles at multiple levels	5%	5%	15%	20%	50%
Engage in co-production	0	5%	15%	25%	55%
Educate, organise and involve others in supporting the Lived Experience (Peer) Workforce	5%	0	15%	25%	55%
Develop trust relationships and authentic connections based on Lived Experience.	0	0	10%	30%	60%

Our staff actively take action to:	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Understand the role and value of Lived Experience in the continuous development of recovery oriented mental health services	0	5%	15%	30%	50%
View People with Lived Experience as having equal expertise to those viewed as 'experts' in the organisation	0	0	15%	25%	55%
'Call out' practices that violate values and principles of Lived Experience work and personal recovery	0	0	15%	35%	50%
Educate other colleagues on the value and benefits of Lived Experience work	0	0	15%	45%	40%
Recommend Lived Experience workers for roles	5%	10%	15%	20%	50%
Advocate for Lived Experience leadership roles	5%	10%	20%	15%	50%
Advocate for meaningful and purposeful co-production	5%	10%	25%	5%	55%
Create formal and informal networks, meetings and processes to increasingly involve more potential allies and Lived Experience workers	5%	0	20%	20%	55%
Guide new Lived Experience workers and share knowledge of navigating internal processes and organisational systems	5%	0	15%	30%	50%
Refer consumers and families to Lived Experience workers.	0	0	30%	25%	45%

Our organisation implements management and governance processes that:	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Demonstrate tangible commitment to workplace conditions and policies that support authentic Lived Experience work	0	0	25%	25%	50%
Will implement a Lived Experience Workforce development strategy plan	5%	0	25%	20%	50%
Promote Lived Experience work across the whole workplace, people accessing services, their families and significant others	5%	0	20%	25%	50%
Maintain the integrity of the Lived Experience (Peer) Workforce consistent with the values and principles of Lived Experience work	5%	0	15%	35%	45%
Encourage collaboration and networking	5%	0	5%	25%	65%
Invest in professional development and career pathways to build Lived Experience leadership	5%	0	15%	30%	50%
Gather data to support evidence of Lived Experience (Peer) Workforce integration and outcomes to support evidence of best practice and funding	5%	5%	5%	45%	40%
Ensure appropriate supervision of the Lived Experience (Peer) Workforce roles that fosters and facilitates integration with the role to foster understanding and collaboration	5%	5%	15%	20%	55%
Build in coproduction as routine practice to identify priorities, assist in planning, decision-making, design, delivery and evaluation of policies, practices, services and roles	5%	5%	20%	25%	45%
Implement dedicated policy, processes and resources for codesign with People with Lived Experience	0	10%	20%	25%	45%
Actively engage Lived Experience (Peer) Workforce and Consumer and/or Carer Representatives in evaluation and quality improvement across the organisation	0	5%	30%	20%	45%
Build in coproduction as routine practice with specific priority groups such as Aboriginal and Torres Strait Islander People	0	5%	25%	15%	55%

Use resources creatively to increase Lived Experience roles	5%	5%	20%	20%	50%
Take a proactive stand against discrimination and prejudicial attitudes	0	0	0	30%	70%
Aim for the highest level of involvement and partnership with People with Lived Experience that is possible in the circumstances	0	10%	5%	25%	60%
Work to co-produce more effective alternatives to restrictive practice	0	5%	15%	25%	55%

Our organisation is committed to funding and policy to:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Invest substantially and sustainably in Lived Experience work	0	5%	25%	30%	0
Ensure sustainable funding allocated for Lived Experience engagement and participation	0	0	20%	50%	0
Identify areas for prioritisation of systemic change and professionalism of Lived Experience (Peer) Workforce in funding, policy, planning and service commissioning	0	0	15%	40%	0
Require service delivery to incorporate Lived Experience roles	5%	0	30%	25%	0
Ensure funding guidelines are informed by best practice e.g. more Lived Experience leadership	5%	0	30%	25%	0
Ensure that the unique roles of Lived Experience Workforce is clearly defined and incorporated into new overarching policies and practices	5%	0	20%	45%	0
Allocate committed funds for Lived Experience (Peer) Workforce development	5%	5%	20%	45%	0
Provide leadership roles for Lived Experience within funding bodies, including government bodies and commissioning bodies	5%	5%	20%	45%	0
Advocate and invest in stable and ongoing Lived Experience roles and Lived Experience Led programs	5%	10%	15%	30%	0
Make meaningful co-design and co-production a requirement of funding	5%	0	20%	30%	0
Fund Lived Experience Led training, research and resource development.	5%	5%	15%	35%	0

TABLE KEY:

Areas of established practice - where the columns Frequent and Routine Practice total 50% or
Areas for development – where the columns Not Current and Developing Practice total 50% or >
Potential gap areas – where the column Neither Agree not Disagree totals 50% or >

Established areas

As most areas were assessed as well-established and rated highly (agree or strongly agree by 50% or more), statements that received ratings above 80% serve as clear indicators of integrated practices. The Self-Assessment results, which show that the integration of Lived Experience is well-established (where Providers scored 80% or higher), include the following areas:

Table 14. Areas of Lived Experience Leadership Considered as 'Established'

Areas of LE Leadership	Established Areas
Culture of support and allyship	• All areas are established
Staff taking action	• Understand the role and value of Lived Experience in the continuous development of recovery oriented mental health services • "Call out' practices that violate values and principles of Lived Experience work and personal recovery • Educate other colleagues on the value and benefits of Lived Experience work • Guide new Lived Experience workers and share knowledge of navigating internal processes and organisational systems
Management and Governance Processes	• Maintain the integrity of the Lived Experience (Peer) Workforce consistent with the values and principles of Lived Experience work • Encourage collaboration and networking

	• Invest in professional development and career pathways to build Lived Experience leadership • Gather data to support evidence of Lived Experience (Peer) Workforce integration and outcomes to support evidence of best practice and funding
Funding and Policy	• Ensure sustainable funding allocated for Lived Experience engagement and participation

Areas for development

When a neutral response rates more highly (30% or more), this should be taken into account when identifying areas for development. The Self-Assessment results that highlight areas for development (where Providers have scored 50% or higher) include the following:

Table 15. Areas of Lived Experience Leadership Considered as 'Developing Areas'

Areas of LE Leadership	Areas for Development
Culture of support and allyship	• Advocate for meaningful and purposeful co-production • Refer consumers and families to Lived Experience workers
Staff taking action	• Demonstrate tangible commitment to workplace conditions and policies that support authentic Lived Experience work • Actively engage Lived Experience (Peer) Workforce and Consumer and/or Carer Representatives in evaluation and quality improvement across the organisation
Management and Governance Processes	• Require service delivery to incorporate Lived Experience roles • Ensure funding guidelines are informed by best practice e.g. more Lived Experience leadership
Funding and Policy	• Require service delivery to incorporate Lived Experience roles • Ensure funding guidelines are informed by best practice e.g. more Lived Experience leadership

APPENDIX: LIVED EXPERIENCE STOCKTAKE SURVEY FOR PHN COMMISSIONED PROVIDERS 2024

Note: The question numbering and some instructions has altered for the purpose of including them in the appendix than how they appear on the survey platform. As the question numbering has not been included in the report, this should not create any confusion in this document.

Section 1: Survey Respondent Details

The following set of questions relate to the person completing the survey

Q1 Name of organisation

Q2 Name of person completing survey

Q3 Position of person completing survey

Q4 Contact phone number

Q5 Contact email address

Section 2: PHN Commissioned Service Providers

The following set of questions relate to Commissioned Service Providers that your organisation provides.

Q6 Which PHN/s are commissioning your organisation to provider mental health, suicide prevention, alcohol and other drugs programs? (select all that apply)

- Adelaide
- Australian Capital Territory
- Brisbane North
- Brisbane South
- Central and Eastern Sydney
- Coordinare South Eastern NSW
- Country SA
- Country to Coast QLD
- Country WA
- Darling Downs and West Moreton
- Eastern Melbourne
- Gippsland
- Gold Coast
- Hunter New England and Central Coast
- Murray
- Murrumbidgee
- Nepean Blue Mountains
- North Coast
- Northern Territory
- Northern QLD
- Northern Sydney

- North Western Melbourne
- Perth North
- Perth South
- Southeastern Melbourne
- South Western Sydney
- Tasmania
- WentWest Western Sydney
- Western NSW
- Western QLD
- Western Victoria

Q7 What commissioned service delivery/programs do you provided? (select all that apply)

- Headspace
- Psychological therapies – for 'hard to reach' people
- Head to Health
- Youth Severe
- Safe Spaces
- Suicide prevention – Indigenous
- Suicide prevention – General
- Alcohol and Other Drugs
- Way Back Support Service
- Early Psychosis Youth Service
- Low Intensity/Early Intervention Services
- Group Therapy
- Digital Mental Health (telehealth, online service)
- Clinical Care Coordination
- Community Campaigns
- Child Youth Specific Programs
- Initial Assessment and Referral
- Older/Aged Specific Programs
- Aboriginal Torres Strait Islander Specific Services
- LGBTQIA+ Specific Services
- Culturally and Linguistically Diverse Specific Services
- Other/s (please specify)

Q8 What areas of commissioned service delivery/programs are Lived Experience (Peer) Workers (employees) involved in your organisation (Select all that apply)

- Headspace
- Psychological therapies – for 'hard to reach' people
- Head to Health
- Youth Severe
- Safe Spaces
- Suicide prevention – Indigenous
- Suicide prevention – General
- Alcohol and Other Drugs
- Way Back Support Service
- Early Psychosis Youth Service
- Low Intensity/Early Intervention Services
- Group Therapy
- Digital Mental Health (telehealth, online service)
- Clinical Care Coordination
- Community Campaigns

- Child Youth Specific Programs
- Initial Assessment and Referral
- Older/Aged Specific Programs
- Aboriginal Torres Strait Islander Specific Services
- LGBTQIA+ Specific Services
- Culturally and Linguistically Diverse Specific Services
- Other/s (please specify)

Q9 Has your organisation undertaken any evaluation/review of Lived Experience engagement activities and/or Lived Experience (Peer Workforce) Commissioned Service Providers?

- Yes – please provide details
- No

Q9.1 If NO: What is the reason you do not undertake evaluation?

- It is not a requirement of the contract/s
- Other barriers (please specify)

Section 3: Lived Experience (Peer) Workforce

The following set of questions relate to People with Lived Experience in your organisations. In this section some questions have been asked specifically in relation to Lived Experience (Peer) Workforce employees or Lived Experience Consumer and/or Carer Representatives.

Q10 What is the total number of Lived Experience (Peer) Workforce employees?

Q11 Please list the position title/s held by each role? (e.g. Lived Experience Peer Worker, Lived Experience Coordinator)

Q12 Please list the classification level/s held by each role (e.g. Level 1, 2 etc)

Q13 Please list the full time equivalent (FTE) held by each role?

Q14 Please list the reporting relationship/s for each role (i.e. position the role reports to)?

Q15 LE Peer Workers direct service delivery - salary range (FTE per annual)

- <$50 000
- $50 000 - $60 000
- $61 000 – $70 000
- $71 000 - $80 000
- $81 000 - $90 000
- >$91 000
- No Peer Support Workers

Q16 Lived Experience Coordinator positions (supporting peer teams) - salary range (FTE per annual) [Multiple-choice – multiple tick options]

- $50 000 - $60 000
- $61 000 – $70 000
- $71 000 - $80 000
- $81 000 - $90 000

- $91 000 - $100 000
- >$100 000
- No PLE Coordinator positions

Q17 Lived Experience Manager/Executive level positions - salary range (FTE per annual) [Multiple-choice – multiple tick options]

- <$60 000
- $61 000 – $70 000
- $71 000 - $80 000
- $81 000 - $90 000
- $91 000 - $100 000
- $101 000 - $110 000
- >$111 000
- No PLE Manager/Executive positions

Q18 What specific training does your organisation provide/access for designated Lived Experience peer work roles (employees)? (Select all that apply)

- Ongoing professional development as with all staff
- Cert IV Mental Health Peer Work (mandatory pre- employment requirement)
- Peer Workforce Training Program (e.g. Cert IV) (an option upon employment)
- Lived Experience/Consumer Engagement/Advocacy training
- Cultural sensitivity training
- Alternative to suicide training program e.g. Alt2Su
- Lived Experience Leadership
- Peer Supervision
- Peer Mentoring
- Community Practice for Peer Workers
- Restrictive Practice Legislation and Guidelines
- Mental Health First Aid
- Team Leader/Manager training
- NSQHS Standards (user guide for health services providing care for People with mental health issues)
- Mental Health Lived Experience Engagement Frameworks/ guidelines
- Lived Experience Workforce Guidelines
- Ongoing capacity building training programs
- No specific training
- Other/s (please specify)

Q19 Total Number of People with Lived Experience (Peer Workforce) or (Consumer or Carer) Representatives?

Q20 What training does your organisation provide to Lived Experience Representatives (Consumers or Carers)? (select all that apply)

- Induction and orientation
- Lived Experience/Consumer engagement/advocacy training
- Cultural sensitivity training
- Alternative to suicide training program
- Lived Experience leadership
- Restrictive Practice Legislation and Guidelines
- Mental Health First Aid

- NSQHS standards (User guide for health services providing care for People with mental health issues)
- Mental Health Lived Experience engagement frameworks/ guidelines
- Lived Experience Workforce Guidelines Working effectively on committees
- Ongoing capacity building training programs
- No specific training
- Others (please specify)

Q21 What (if any) sitting fee/honorarium do Lived Experience Representatives partnering with your organisation receive for participating in engagement activities? (Select all that apply)
- No sitting fee or honorarium
- Sitting on Committees
- Contributing to codesign activities (i.e. policy review, service/program development)
- Providing Lived Experience/consumer led training
- Participating as Lived Experience Representatives in audits/evaluations
- Participating in other involvement and engagement activities (e.g. focus groups/workshops etc)
- Other/s (please specify)

Q22 What (if any) engagement activities are not paid a sitting fee/honorarium in your organisation?

Q23 What other activities do People with Lived Experience, those in both Lived Experience (Peer) Workforce roles and Lived Experience Representative (Consumer and Carer) roles hold? (select all that apply)
- Lived Experience speakers, trainers, educators (for staff training)
- Lived Experience speakers, trainers, educators (for consumer representative training)
- Lived Experience researchers/evaluators
- Lived Experience internal auditors/reviewers
- Tender Assessment Panels
- Research Advisory Committees/Working Groups
- Staff recruitment panels
- None of these roles
- Others (please specify)

Section 4 Integration of Lived Experience Engagement

Q24 What policies and/or procedures in your organisation specifically refer to/relate to Lived Experience Engagement (select all that apply)
- Consumer/Carer Engagement policies and procedures
- Diversity and Inclusion policy and processes
- Organisation's Lived Experience engagement framework/action plan
- Lived Experience Representative role description
- Carer Representative role description
- Induction/training program materials
- Sitting fee/honorarium policy and procedures
- Lived Experience membership/responsibilities in committee terms of references
- Consumer Advisory Committee action plans
- Register of consumer driven safety actions/quality Improvements
- Other/s (please specify)

Q25 Does your organisation include People with Lived Experience, Consumers and/or Carer Representatives, as partners in governance and management structures?

- Yes
- No

Q25.1 If No: What do you believe are the challenges for your organisation to establish and involve People with Lived Experience Consumer and/or Carer Representatives (select all that apply)

- Commitment from Executive to incorporate Lived Experience Representative roles in organisational governance structure
- Identification of specific Lived Experience Representative roles and key committees for placement
- Development of Lived Experience engagement /action plan
- Allocation/conformation of funding
- Development of Lived Experience (Peer) Workforce policies and processes
- Staff training to understand Lived Experience Consumer or Carer Representative roles and functions
- Development of Lived Experience position statement/s
- Recruitment of Lived Experience Consumer or Carer Representatives
- Access to Lived Experience training programs (e.g. due to geographical remoteness)
- Travel costs/logistics for attendance for People with Lived Experience in remote locations
- Strategies for engaging with 'hard to reach' groups
- Other/s (please specify)

Q26 What specific committees in your organisation include People with Lived Experience? (select all that apply) No specific target groups committees

- Mental Health Lived Experience Advisory Committee/Reference Group
- Aboriginal and Torres Strait Islander Advisory Committee/Reference Group
- Culturally and Linguistically Diverse (CALD) Committee/Reference Group
- LGBTQIA+ Committee/Reference Group
- Suicide Prevention Committee
- Child and Youth Health Committee
- Severe and Complex Review Committee
- Alcohol and Other Drugs Committee
- Other/s (please specify)

Q27 What is the total number of Lived Experience Consumer or Carer Representatives engaged across your organisation?

Q28 How many People with Lived Experience make up members on your organisation's Consumer Advisory Committee?

Q29 Provide a case study on your organisation's Lived Experience engagement activities with one or more of the following groups. (Select all that apply)

- Aboriginal and Torres Strait Islanders communities
- Alcohol and Other Drugs
- LGBTIQIA+
- Culturally and Linguistically Diverse (CALD)
- Older People/Aged Care (aged 54 +)
- Any other group (please specify)

Please upload a case example selected from this question

Q30 What specific strategies do you use to actively involve and engage with priority groups?

Q31 How inclusive do you believe your organisation is in employing and/or engaging with Lived Experience (Peer) Workforce roles that reflect the diversity and intersectionality of People with Lived Experience?

Q32 Has integrating Lived Experience (Peer) Workforce, as a requirement of Commissioned Service Providers, enhanced/expanded your organisation's inclusion of People with Lived Experience more broadly across your organisation?

- No – our organisation has established Lived Experience (Peer) Workforce and engagement strategies already
- Yes – Please provide details of how this has enhanced People with Lived Experience participation

Section 5: Assessment of the organisation's integration of Lived Experience engagement involvement and roles

This section presents a number of statements on how your organisation embeds Lived Experience and participation activities across design, planning, governance, service delivery and evaluation.

Q33

Using the scale, rate how you believe your organisation has integrated People with Lived Experience engagement relevant to each statement, from not currently in practice through to routine practice.

Statements relation to the Service/Program	**Likert Scale**			
	Not current practice	Developing Practice	Frequent Practice	Routine Practice
We use a standardised codesign approach in developing and reviewing our organisation's services and programs				
We have Lived Experience members on service and program steering committees and/or reference groups				
We have integrated Lived Experience (Peer) Workers across our organisation's services and programs				
We provide Peer Led mental health programs (e.g. Alt2Su)				

Q34

Using the scale, rate how you believe your organisation has integrated People with Lived Experience engagement relevant to each statement, from not currently in practice through to routine practice.

Statements relation to the Organisation	**Likert Scale**			
	Not current practice	Developing Practice	Frequent Practice	Routine Practice
We have Lived Experience representation on key governance committees outlined in Terms of Reference.				
We have an established Consumer Advisory Committee with Lived Experience Representative members				
We have established specific advisory committee/reference groups for priority groups with Lived Experience representation				
People with Lived Experience participate as speakers/trainers as part of induction and orientation of staff and consumers				
We support, promote and commission access to training programs specific to supporting People with Lived Experience				
Our Lived Experience roles reflect diversity of our workforce, service users and the community				

Q35

Using the scale, rate how you believe your organisation has integrated People with Lived Experience engagement relevant to each statement, from not currently in practice through to routine practice.

Statements relation to the Policy	**Likert Scale**			
	Not current practice	Developing Practice	Frequent Practice	Routine Practice
We develop and review policies in codesign with People with Lived Experience				
We have developed specific engagement policies and processes in codesign with People with Lived Experience				
Our policy reflects, promotes and facilitates diversity and inclusion of People with Lived Experience				

Q36

Using the scale, rate how you believe your organisation has integrated People with Lived Experience engagement relevant to each statement, from not currently in practice through to routine practice.

Statements relation to the Audit and Evaluation	**Likert Scale**			
	Not current practice	Developing Practice	Frequent Practice	Routine Practice
People with Lived Experience participate as internal auditors and reviewers as part of clinical governance				
People with Lived Experience participate as internal auditors and reviewers as part of service delivery monitoring and review				
People with Lived Experience participate in governance oversight and monitoring				
People with Lived Experience participate as partners in research and research evaluation				
We audit and review our involvement activities and the level of Lived Experience contributions to ensure best practice				
We collaborate with other organisations across other jurisdictions in shared learning to compare and evaluate our practices and strategies and to improve Lived Experience involvement and engagement				

Section 6 Engagement Framework

The following questions relate to your organisation's Engagement Framework activities.

Q37 Does your organisation use a specific engagement framework/guidelines and/or model (either an internally developed or an external engagement framework) to integrate strategies and actions for involving and partnering with People with Lived Experience?

- Yes
- No

Q37.1 If Yes: What Engagement Framework/Guidelines and/or model does your organisation use? (select all that apply)

- Organisation developed consumer, carer and community engagement framework
- Organisation developed specific mental health Lived Experience engagement framework
- National Mental Health Commission's Consumer and Carer Engagement: a practical guide
- National Lived Experience Development Guidelines
- The Lived Experience Governance Framework
- Other/s (please specify)

Q37.2 If 'no': What strategies and activities does your organisation use to integrate consumer engagement and participation activities in design, planning, governance, service delivery and evaluation?

Q38 Has your organisation undertaken any collaborative Lived Experience engagement activities with other local, state, national and/or international stakeholders?

- Yes - Please provide an example of a collaborative activity
- No

Q39 What evidence/data does your organisation currently collect to monitor and measure the effectiveness of your Lived Experience engagement strategies and activities?

Q40 What do you believe should be reported in relation to engaging with People with Lived Experience in the future?

Section 7: Levels of Involvement

This section I framed to be consistent with the National Mental Health Commission's Consumer and Carer Engagement Guide. (Please refer to the guide inf required). The spectrum of engagement outlines increasing consumer control and decision-making across the levels of engagement and participation. The following questions ask you to provide information about the strategies your organisation has implemented to engage with People with Lived Experience across the levels of involvement.

Q41 Select the levels of consumer participation that People with Lived Experience are engaged at in your organisation (select all that apply)

- Inform
- Educate
- Consult
- Engage
- Codesign
- Coproduction
- Lived Experience Led/Empower

Q42 **INFORM: Provide information** for People with Lived Experience to assist them in shared decision-making your organisation has implemented.
What main strategies do you use to **INFORM** People with Lived Experience (select all that apply)

- To provide information to enhance health literacy
- How to find reliable health information/resources
- To provide information to support decision-making (e.g. options, benefits, risks, costs)
- Shared decision-making, or making decisions on behalf of someone else
- Care planning
- When to seek advice
- About access to services (service types, location, cost, eligibility)
- About healthcare rights
- Contact/help/assistance information
- How to give feedback or make a complaint
- About community supports
- About consumer engagement/participation
- Organisation performance information
- Use of written information (e.g. brochures, fact sheets)
- Through websites (your organisation or other website)
- Via social media
- Through other organisations
- Other/s (please specify)

Q43 **EDUCATE: Provide education** to support learning to assist People with Lived Experience to understand problems, alternatives and solutions, your organisation has implemented.
What main strategies do you use to **EDUCATE** People with Lived Experience (select all that apply)

- 1:1 education with clinician and consumer
- Support/Peer groups
- 1:1 through Peer Workforce
- Online resources/education technology
- Health promotion resources
- Self-help tools/supports
- Decision-making tools
- Community campaigns
- Health promotion campaigns
- Other/s (please specify)

Q44 **CONSULT: Gain feedback** from People with Lived Experience to inform and influence decision-making and find alternative solutions in organisation's design, planning, governance, service delivery and evaluation, your organisation has implemented.
What main strategies do you use to **CONSULT** People with Lived Experience (select all that apply)

- Consumer Advisory Committee
- Target groups specific advisory committee/reference group
- Organisation led community forums
- Targeted online surveys/questionnaires
- Experience of service surveys
- Through community groups/networks
- Via social media
- Organisation led focus groups/workshops
- Other/s (please specify)

Q45 **ENGAGE: Work with People with Lived Experience throughout a process** to ensure their perspectives, opinions and concerns are consistently understood and considered in decision-making. (eg establishment of mental health advisory committee/reference group; People with Lived Experience participate in accreditation preparation and audit)
What main strategies do you use to **ENGAGE** People with Lived Experience (select all that apply)

- Report back on progress
- Provide updates on work progress
- Provide organisation performance reports for feedback e.g. S&Q, complaints
- People with Lived Experience participate in service/program monitoring, evaluation
- People with Lived Experience on recruitment/interview and selection panels
- Lived Experience members on project steering committees/ working groups
- Lived Experience members on tender/commissioning panels
- Lived Experience Researchers and/or preparation of research applications
- Other/s (please specify)

Q46 **CODESIGN: People with Lived Experience partner in identifying and creating** an initiative that meets the needs, expectations and requirements of all those who are impacted by the outcome.
COPRODUCTION: People with Lived Experience partner in implementing, monitoring and evaluating systems and/or services.
What main strategies do you use to **CODESIGN OR COPRODUCE** with People with Lived Experience (select all that apply)

- Development of organisation's Lived Experience engagement framework
- Codesign of experience of service surveys
- Codesign of policies/processes

- Mental health service surveys
- Lived Experience members on a specific project steering committee
- People with Lived Experience developed alternative option/solutions for mental health program
- Peer Workforce auditors/interviewers
- People with Lived Experience evaluate organisation's engagement strategies
- Other/s (please specify)

Q47 **LIVED EXPERIENCE LED / EMPOWER:** People with Lived Experience (individuals, groups or communities) lead/have control over decision-making, solutions and activities (including decisions to collaborate and/or seek support) in an initiative or process.
What main strategies do you use to **LIVED EXPERIENCE LED /EMPOWER People with Lived Experience** (select all that apply)

- Lived Experience/Peer Led programs (e.g. suicide prevention program)
- Lived Experience/Peer Led education/training
- Consumer and Carer/Peer Led - Lived Experience project initiated by the consumer advisory committee
- Consumer/Peer Led research
  Implementation of a consumer Led project steering committee
  Other/s (please specify)

Q48 What do you believe are the ongoing challenges for your organisation to implement participation to increase People with Lived Experience control and decision making across the following levels of engagement and participation? (Select all that apply)

- Level, range and scope of involvement and engagement strategies currently used in the organisation
- Confidence to try new and innovative involvement and engagement approaches
- Commitment of senior management/staff to expand level of involvement and partnership with People with Lived Experience
- Level of skill and experience of managers/senior staff in involving and partnering with People with Lived Experience
- Data collection and measurement of value of involvement
- Allocation of funding for staff to undertake training to involve and partner with People with Lived Experience
- Managing the involvement activities and engagement processes (planning, resourcing, coordination)
- Digital engagement strategies
- Effectively involving People with Lived Experience in involvement and engagement activities
- Reactive or tokenistic rather than purposeful involvement and codesign
- Level of understanding and application of levels of involvement
- Need for clear action plan to implement involvement and partnership activities with people hard to reach' groups
- Other/s (please specify)

Section 8: Levels of involvement case studies

Select the 2 highest levels of involvement you have implemented in the last 12 months and provide a case study for each level. Each case study should include a case study name; who was involved; what activities were undertaken; what were the outcomes, leanings and challenges. Where relevant share/attach any reports related to this case study.

Q49 Case Study 1

What level of involvement is this case study demonstrating

- Inform
- Educate
- Consult
- Engage
- Codesign
- Coproduction
- Lived Experience Led / Empower

Name of Case Study
Outline number of people involved and roles (staff, Lived Experience (Peer) Workforce, external participants)
Outline all of the activities that were undertaken and how they demonstrate the level of involvement you have identified
Outline the learnings gained through this strategy
Outline the challenges experienced in implementing this strategy
Please upload any documents relevant to this case study

Q50 Case Study 2
What level of involvement is this case study demonstrating

- Inform
- Educate
- Consult
- Engage
- Codesign
- Coproduction
- Lived Experience Led / Empower

Name of Case Study
Outline number of people involved and roles (staff, Lived Experience (Peer) Workforce, external participants)
Outline all of the activities that were undertaken and how they demonstrate the level of involvement you have identified
Outline the learnings gained through this strategy
Outline the challenges experienced in implementing this strategy
Please upload any documents relevant to this case study

Section 9: Summary Assessment of People with Lived Experience Engagement

The following section is a self-assessment of your organisation's level of leadership in achieving integration of People with Lived Experience in planning and service delivery across the organisation.

Q51

Score to what degree you agree or disagree with each of the following statements.

Statements relation to the Our organisation promotes a culture of support and allyship to:	**Likert Scale**				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Actively oppose discriminatory language, policies and practice					
Actively and vocally support the work of the Lived Experience (Peer) Workforce					
Actively advocate for Lived Experience positions and funding					
Work collaboratively and respectfully in authentic partnerships					

Defer to and step aside to credit Lived Expertise and share power
Facilitate opportunities for Lived Experience leadership
Seize opportunities to creatively use resources and invest in Lived Experience roles
Advocate for Lived Experience roles at multiple levels
Engage in co-production
Educate, organise and involve others in supporting the Lived Experience (Peer) Workforce
Develop trust relationships and authentic connections based on Lived Experience.

Q52

Score to what degree you agree or disagree with each of the following statements.

Statements relation to the Our staff actively take action to:	**Likert Scale**				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Understand the role and value of Lived Experience in the continuous development of recovery oriented mental health services					
View People with Lived Experience as having equal expertise to those viewed as 'experts' in the organisation					
'Call out' practices that violate values and principles of Lived Experience work and personal recovery					
Educate other colleagues on the value and benefits of Lived Experience work					
Recommend Lived Experience workers for roles					
Advocate for Lived Experience leadership roles					
Advocate for meaningful and purposeful co-production					
Create formal and informal networks, meetings and processes to increasingly involve more potential allies and Lived Experience workers					
Guide new Lived Experience workers and share knowledge of navigating internal processes and organisational systems					
Refer consumers and families to Lived Experience workers.					

Q53

Score to what degree you agree or disagree with each of the following statements.

Statements relation to the Our organisation implements management and governance processes that:	**Likert Scale**				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Demonstrate tangible commitment to workplace conditions and policies that support authentic Lived Experience work					
Will implement a Lived Experience Workforce development strategy plan					
Promote Lived Experience work across the whole workplace, people accessing services, their families and significant others					
Maintain the integrity of the Lived Experience (Peer) Workforce consistent with the values and principles of Lived Experience work					
Encourage collaboration and networking					

Invest in professional development and career pathways to build Lived Experience leadership
Gather data to support evidence of Lived Experience (Peer) Workforce integration and outcomes to support evidence of best practice and funding
Ensure appropriate supervision of the Lived Experience (Peer) Workforce roles that fosters and facilitates integration with the role to foster understanding and collaboration
Build in coproduction as routine practice to identify priorities, assist in planning, decision-making, design, delivery and evaluation of policies, practices, services and roles
Implement dedicated policy, processes and resources for codesign with People with Lived Experience
Actively engage Lived Experience (Peer) Workforce and Consumer and/or Carer Representatives in evaluation and quality improvement across the organisation
Build in coproduction as routine practice with specific priority groups such as Aboriginal and Torres Strait Islander People
Use resources creatively to increase Lived Experience roles
Take a proactive stand against discrimination and prejudicial attitudes
Aim for the highest level of involvement and partnership with People with Lived Experience that is possible in the circumstances
Work to co-produce more effective alternatives to restrictive practice

Q54

Score to what degree you agree or disagree with each of the following statements.

Statements relation to the Our organisation is committed to funding and policy to:	**Likert Scale**				
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Invest substantially and sustainably in Lived Experience work					
Ensure sustainable funding allocated for Lived Experience engagement and participation					
Identify areas for prioritisation of systemic change and professionalism of Lived Experience (Peer) Workforce in funding, policy, planning and service commissioning					
Require service delivery to incorporate Lived Experience roles					
Ensure funding guidelines are informed by best practice e.g. more Lived Experience leadership					
Ensure that the unique roles of Lived Experience Workforce is clearly defined and incorporated into new overarching policies and practices					
Allocate committed funds for Lived Experience (Peer) Workforce development					
Provide leadership roles for Lived Experience within funding bodies, including government bodies and commissioning bodies					
Advocate and invest in stable and ongoing Lived Experience roles and Lived Experience Led programs					
Make meaningful co-design and co-production a requirement of funding					
Fund Lived Experience Led training, research and resource development.					

ABOUT LELAN:

LELAN is the independent peak body in South Australia *by*, *for* and *with* people with lived experience of mental distress, social issues or injustice. Our purpose is to amplify the voice, influence and leadership of people with lived experience to drive systemic change. LELAN has led philanthropic, state and federally funded projects as well as completed commissioned pieces of work.

LELAN's systemic advocacy targets the mental health and social sectors in South Australia, whilst our thought leadership and expertise on lived experience expertise and leadership is borderless.

By centring the experiences, collective insights and solution ideas of people with lived experience in all of our work, as well as being immersed in the lived experience community from grassroots to strategic and governance levels, LELAN demonstrates the principles, practices and change dynamics that the social sector is calling for and desperately needs. Because of our strong and trusted relationships with people in the lived experience community we are able to have deeper conversations about things that matter, drawing our collective experiences and action together in purposeful ways.

LELAN has extensive experience and a proven methodology for leading lived experience-led and/or co-creation initiatives, frequently with a focus on sensitive issues and including groups that bring divergent perspectives to the conversation. The organisation has three external facing strategic pillars:

- Developing the capability and influence of people with lived experience.
- Nurturing organisational and sector capacity for partnering with people with lived experience, and
- Impacting system improvement agendas to benefit people with lived experience.

LELAN was founded in 2017, and the organisation received its first funding in 2019. Pivotal pieces of work completed in partnership and/or led by LELAN with the lived experience community include the groundbreaking *Model of Lived Experience Leadership* that launched in 2021, as well as *The Lived Experience Governance Framework* and *A Toolkit to Authentically Embed Lived Experience Governance* that were released in July 2023 (all available at www.lelan.org.au/shared-resources).