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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)

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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.

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).