MENTAL HEALTH **CONSUMER LIVED EXPERIENCE WORKFORCE** DISCIPLINE FRAMEWORK

This framework is part of a suite of five discipline frameworks for the lived and living experience workforces in Victoria:

- The Mental Health Consumer Lived Experience Workforce Discipline Framework (Victoria)
- The Mental Health Family Carer Lived Experience Workforce Discipline Framework (Victoria)
- The Harm Reduction Lived and Living Experience Peer Workforce Discipline Framework (Victoria)
- The Alcohol and Other Drug (AOD) Lived Experience Workforce Discipline Framework (Victoria)
- The Alcohol and Other Drug (AOD) Family Lived Experience Workforce Discipline Framework (Victoria)

This project was made possible with funding from the Department of Health

VICTORIA State Government

Published by:

CENTRE FOR MENTAL HEALTH NURSING
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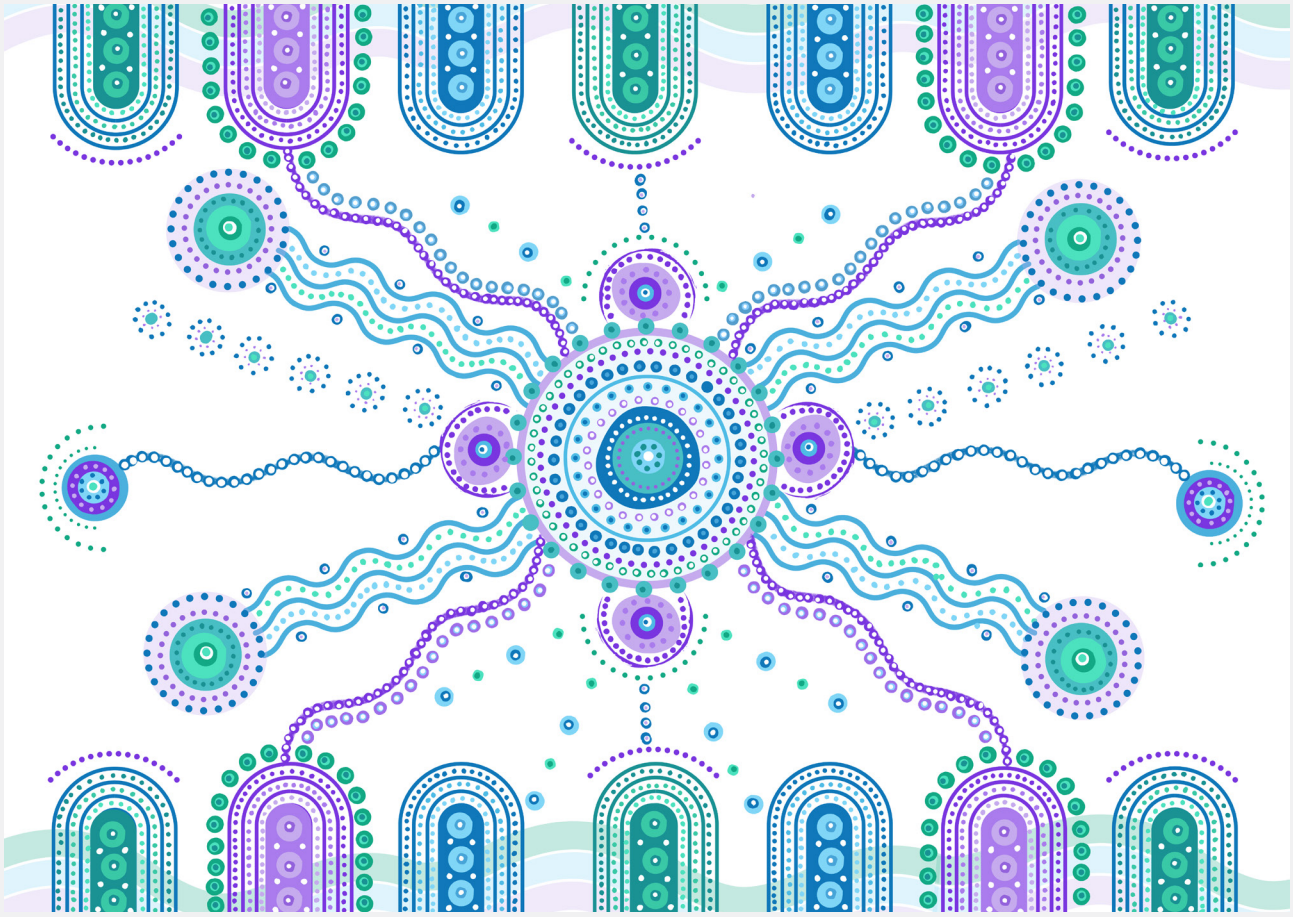
ACKNOWLEDGEMENT OF COUNTRY

The University of Melbourne would like to pay our deepest respects and acknowledge the Traditional Custodians of the unceded lands on which we live, work and learn: the lands of the Wurundjeri Woi-wurrung and Bunurong peoples (Burnley, Fishermans Bend, Parkville, Southbank and Werribee campuses), Yorta Yorta peoples (Dookie and Shepparton campuses), and Dja Dja Wurrung peoples (Creswick campus).

The University acknowledges all Elders, past and present and the Knowledge Holders of all Indigenous nations and clans across Australia. With a deep ancestral connection dating back more than 60,000 years, we recognise the strength and resilience that all Aboriginal and Torres Strait Islander peoples carry when caring for Country and upholding Cultural practices and Lore.



Wala Garia (Strong Spirit) *2024. "A reflection of the interconnectedness and siloing of the mental health sector." Shibs, Proud Wulgurukaba-Gunggandji woman*

FURTHER ACKNOWLEDGEMENTS

Recognising lived experience

This Framework was developed by people with consumer lived experience and has been built upon decades of work through grassroots efforts, community-based work, innovative thinkers, creatives and people working in the system to affect change. The Framework has been informed by the long-standing work of the consumer movement and the consumer lived experience workforce.

Expert Knowledge Group

Throughout the development of the Framework, the Consumer Academic Program team engaged with a panel of workforce experts—the Expert Knowledge Group—comprised of professionals with extensive experience in consumer lived experience roles. The insights of the were instrumental in co-creating the content of the Framework, ensuring it reflects both theoretical knowledge and practical realities. We would like to thank the members of the Expert Knowledge Group for generously contributing their wisdom and knowledge to the development of the Framework.

RMIT research participants

We would like to extend a thank you to consumer workforce members who contributed to the research led by RMIT University.

First Nations Working Group

We offer deep thanks and appreciation to the members of the First Nations Working Group who contributed their time, expertise and knowledge to the development of the First Nations perspectives section of the Framework and helped embed First Nations perspectives throughout.

Further thanks

Thank you to the Department of Health, without which this Framework would not have come to be. In particular, thank you to Emanjilli Hunt, Emma Cadogan and Bianca Childs for supporting the undertaking of this work.

Thank you to the other lived and living experience discipline leads who were developing frameworks at the same time (the Lived and Living Experience Framework Development Collaborative Group). The time spent co-working and supporting each other was invaluable.

Thank you to Bridget Hamilton, Director Centre for Mental Health Nursing for providing the Consumer Academic Program team guidance throughout this process.

Thank you to Shibs Sharpe for creating many of the meaningful graphics within the Framework.

FOREWORD

The development of the Consumer Lived Experience Workforce Discipline Framework (Victoria) was facilitated by the Consumer Academic Program team at the Centre for Mental Health Nursing, Melbourne University, with funding from the Department of Health. The Framework was co-created by the Consumer Academic Program team and consumer academics at RMIT made up of the following researchers and authors, whose hard work and dedication brought this Framework to fruition:

Centre for Mental Health Nursing, University of Melbourne:

- Nina Joffee-Kohn
- Cat Van Remmen
- Cath Roper
- Shibs Sharpe
- Caitlin Kozman
- Leanna Azoury
- Puneet Sansanwal
- Leah McKenner
- Tash Swingler
- Vrinda Edan

Centre for People, Organisation and Work, RMIT University:

- Helena Roennfeldt
- Dr Melissa Chapman
- Dr Louise Byrne

Recognising the vital role of diverse consumer perspectives, the Framework is underpinned by a commitment to consumer-led principles. It emphasises the importance of training, learning, and development tailored to the unique needs of the consumer lived experience workforce. Central to this Framework are the theories and knowledge that guide our discipline, ensuring that our work is grounded in values and principles that are central to the consumer lived experience workforce's ways of working.

The Framework acknowledges the significance of First Nations perspectives, integrating First Nations knowledge to support the social and emotional wellbeing of First Nations consumers and consumer workers alike. It advocates for inclusivity, recognising the diverse experiences within the workforce and the need for inclusive practices that address varying social identities.

Through clear definitions of scope of practice and supportive professional environments including consumer perspective supervision and communities of practice, this Framework aspires to elevate the contributions of the consumer lived experience workforce within community, public and private mental health and wellbeing services.

GLOSSARY

Biomedical model: a traditional medical system used in clinical work and research that considers biological processes as underlying causes of psychiatric illness in individuals and regard mental illnesses as brain diseases.[1,2]

Consumer Academic Program (CAP): Consumer Academic Program, Centre for Mental Health Nursing, University of Melbourne

Culturally and Racially Marginalised (CARM): can refer to groups of people who are not white and are Black, Brown, Asian, or any other non-white group, who face marginalisation due to their race, their culture, religion, or background.[3]

Co-design: one component and stage of co-production among co-planning, co-delivery, and co-evaluation.[4]

Community of Practice (CoP): is a method of understanding and learning in workplaces and can be defined as "a network of people who work on similar processes or in similar disciplines, and who come together to develop and share their knowledge in that field for the benefit of both themselves and their organisation(s)."[5]

Connection: "Lived/common experience is used to make connection in the relationship. Connection is the basis on which trust and meaningful, effective learning [and healing] is possible."[6]

Consumers: the word 'consumer' is commonly used to describe people who have used mental health services. The term is not wholly accepted by all people who access mental health services, however, there was agreement by local Victorian consumers in the 1990s to use this term.[7] We use this term as it came from the consumer/survivor movement.

Consumer perspective: a perspective acquired through accessing services in the mental health system. It is based on a belief that individual consumers are 'the experts' about their own life and carry the wisdom to best articulate their own needs when accorded the time, space and means to do so. It is an idea that developed out of a collective consciousness and political solidarity that grew from the consumer/survivor movement and provides a way of looking at the world from the point of view of a group that has been marginalised and discriminated against.[8,9]

Consumer perspective work: we use the term 'consumer perspective work' to mean the active utilisation of personal lived experience of distress, crisis, and/or service use as well as an understanding and utilisation of the 'collective knowledge' of the consumer movement. "Decades of dedicated thought, debate, study and work has generated an alternate, empowering way of viewing ourselves and our experiences outside the bio-medical lens."[10]

Consumers/survivors: A group of people who identify as consumers, survivors, or ex-patients of mental health services and have survived experiencing marginalisation and systemic oppression within the mental health system having survived. Consumer/survivors share experiences of social, cultural, and legal discrimination, harmful myths, severe socioeconomic and health disadvantages, violence, and abuse.[11,12,13]

Consumer/survivor movement: the consumer/survivor movement originated in the late 1960s and early 1970s and has historical roots influenced by movements such as civil rights movement, Black/African American rights movement, Women's Movement for the rights to vote, Physical Disabilities Movement, Gay (LGBTQI+) Movements and movements against psychiatric abuse (Psychiatric Survivors Movement). The consumer/survivor movement benefited from the activism early leaders and thought experts such as Judi Chemberlin, an ex-patient and co-founder of the Mental Patients' Liberation Front and Merinda Epstein, a pioneer in the consumer/survivor movement in Australia.[14,15,16]

Co-production: "is a way for participants with different expertise to collaboratively work together"[17] . Co-producing with consumers involves defining the problem, designing and delivering the solution, and evaluating the outcome together.[18]

Co-option: "is a process by which a dominant group attempts to absorb or destroy anything believed to pose a threat to its hold on ongoing power through minimising the agenda of the weaker group.[19] Several examples from the consumer/survivor movements indicate words that may be co-opted such as 'recovery' (linked with clinical outcomes), diagnoses, empowerment and marginalisation.[20]

Discipline: a term used to describe specific areas of knowledge, research and education within organisations and institutional settings.[21]

Discipline specific supervision: "Supervision provided by another person from the same discipline as those receiving it. For example, a social worker being supervised by a fellow social worker, or a peer support worker being supervised by another peer support worker."[22]

Expert Knowledge Group (EKG): A panel of workforce experts comprised of professionals with extensive experience in consumer lived experience roles. The insights of the EKG were instrumental in co-creating the content of the Framework, ensuring it reflects both theoretical knowledge and practical realities.

First Nations perspective: can be termed as "recognition of traditional owners and their knowledge of Country, cultural values and traditions that influence urban design, and governance."[23]

the Framework: The Mental Health Consumer Lived Experience Workforce Discipline Framework (Victoria).

Grey literature: covers a range of material from blogs, conference papers/conference proceedings, fact sheets, government documents, government reports, informal communication, newsletters, pamphlets, policy statements, reports, research data, surveys, theses, social media etc. It is considered that grey literature may not be available in traditional channels of publishing and distribution in academic databases. It provides the readers with new information that would not readily available through conventional channels and may be difficult to identify and access.[24,25,26]

Intersectionality: Kimberlé Crenshaw coined the term intersectionality in 1989 to describe the experiences of discrimination experienced by people who have multiple identities that are marginalised in society. Crenshaw has described intersectionality as "a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking."[27] Within intersectionality, various systems, power relations and social relations interact with and can be mutually shaped by interrelated factors such as individuals' race, class, gender, sexuality, nationality, ability, ethnicity and age.[28,29]

Lived experience roles: "Lived experience (LE) roles in mental health, are distinguished from clinical roles by the use of lived expertise and experiential knowledge gained through experiences of diagnosis, service use, and personal recovery from mental health challenges for the purpose of helping others and contributing to system change."[30]

Literature review: a systemic way of collecting and synthesising previous research as building blocks of academic research activity to advance knowledge and facilitate theory development.[31]

Lived and Living Experience Workforces (LLEWs): includes workers in designated lived and living experience workforce positions across the mental health including consumer, Alcohol and Other Drug (AOD) treatment, harm reduction, and family/carer sectors.[32]

Madness: consumers and survivors consider madness as part of an individual's identity and a human variation such as trauma through which breakthroughs and advancement in ways of living become possible.[33]

Marginalisation: is considered a global and social problem that negatively impacts certain groups by pushing them to the margins of society thus limiting their ability to participate.[34,35]

The Act: Mental Health and Wellbeing Act 2022 (VIC).

Peer drift (also referred to as role drift): peer drift is a term used to describe when practice moves away from consumer principles and practices. 'Peer drift' can happen in situations where a service does not fully understand the unique nature of the consumer worker's role and they are given tasks that are more clinical.[36]

Self-care: in a social justice context, the term self-care emerged from the history of Black communities and Black activists who were pushed to care for themselves for survival due to social oppression and racial inequalities.[37] Self-care in this context has been understood from a quote in the epilogue of Audre Lorde's 1988 publication, A Burst of Light: "Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare." It has been explained that self-care is political when one is battling systems and structures of oppression that are against you.[38]

Social and Emotional Wellbeing (SEWB): a term commonly used by Aboriginal and Torres Strait Islander peoples to encompass all aspects of their life when considering their wellbeing. It reflects their Connection to Country, Spirit, Body, Mind, Family and Kinship, Community and Culture. It also recognises the historical, social and political determinants that may impact on their wellbeing.[39]

Social justice: is a basic human right to a life of opportunity and dignity that is free from discrimination and not disadvantaged.[40]

Supervision: "it is a facilitated exchange between practicing professionals to enable the development of professional skills" and a "supported space for the individual [worker] to reflect on their professional practice in such a way that growth, development and learning are promoted."[41,42]

Yarning: is considered a protected space where traditional methods of imparting knowledge by Aboriginal elders occur following principles and protocols. Yarning methods used in modern research are informed by Indigenous knowledge and promote relationality.[43]

INTRODUCTION

A discipline framework is a guide that articulates the skills and knowledge needed to perform a discipline role in a particular field of work. It establishes underpinning values and principles, theories and knowledge and a scope of practice of the discipline.

Lived and Living Experience Workforces (LLEWs) are implemented in a way that acknowledges the fact that they are forever learning, growing and incorporating multiple lived and living experience perspectives that are ever evolving. Therefore, the frameworks will require regular review with a group of diverse leaders in the field.

Lived and Living Experience disciplines have a deep knowledge base, practice base and lived experience expertise that enables unique connections, and informs ways of knowing, being and doing.

The importance of a discipline framework

A discipline framework sets down the values and principles informing our discipline, providing consistency for how and what the consumer workforce undertakes in its roles. In particular, this Framework provides direction and guidance for people who are new to the consumer workforce.

With our own discipline, we have a seat at the table alongside all other LLEW disciplines. A framework can also help to make ethical decisions, because it sets out the values and principles guiding the work. Because this Framework has been developed by consumer workers for consumer workers, we expect it will also improve experiences for consumers they work with. Finally, this Framework aims to provide ideas and information that can help consumer workers to put words to experiences they might not yet have found language to express.

The development of the Framework

The CAP team has developed a comprehensive discipline framework for the consumer lived experience workforce, funded by the Department of Health. This initiative is part of a broader effort, in conjunction with other LLEWs including Self Help Addiction Resource Centre (SHARC), Harm Reduction Victoria (HRVic), and Tandem, to create cohesive frameworks that enhance the development of lived and living experience roles within the mental health and wellbeing sector.

The CAP team conducted a literature review and engaged consumer academics from RMIT University to gather and analyse diverse perspectives within the consumer lived experience workforce. This research aimed to capture the unique insights and contributions of consumer workers.

The CAP team created a group—the EKG—to co-develop the content for the Framework. The CAP team co-created the agenda for the EKG's work with members. EKG members unanimously agreed to use the sessions to develop the Scope of Practice section of the Framework.

A First Nations working group was established to develop the First Nations Perspectives section and embed First Nations perspectives throughout the Framework.

In addition, the CAP team reached out to the wider sector through an anonymous sector survey. The sector survey was also publicised in the Centre for Mental Health Learning's (CMHL) consumer lived experience Basecamp group.

The CAP team is committed to ongoing collaboration with the consumer lived experience workforce to refine and implement this Framework, ensuring it meets the evolving needs of both the workforce and the communities they serve.

Literature review findings

A literature review was conducted by the CAP team to understand the knowledge base on what is distinctive about the consumer workforce. The findings of the literature review focused on how the consumer lived experience workforce describes and undertakes our discipline. It also explored how a discipline framework will benefit the sector and address barriers currently faced by the consumer workforce.

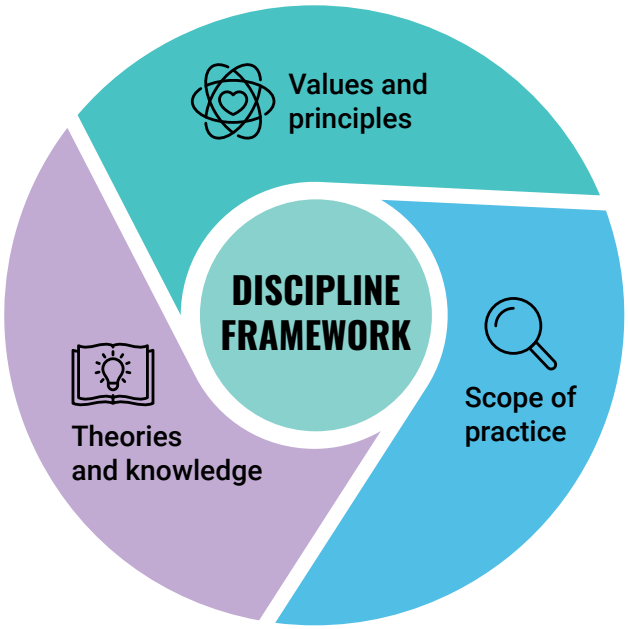
Our analysis highlighted the emergence of consumer lived experience workforces within mental health sectors globally. Originating from activist movements, these workforces advocate and build awareness around the need for improved rights of consumers. In addition, our findings highlight common workplace experiences of consumer lived experience workforce members, including experiencing a lack of clarity in the scope of practice, instances of discrimination at work, and uncertainty regarding consumer lived experience workforce members' positions within multi-disciplinary teams.

The literature demonstrates that the consumer lived experience discipline is unique and requires a clear framework that outlines values and principles, scope of practice, and theories and knowledge.

A review of literature from our sector has demonstrated that consumer work has:

1. Unique values and principles
2. Unique knowledge, abilities and attributes
3. Unique perspectives
4. Unique contributions and benefits to the mental health sector
5. Unique roles and purposes within the sector
6. Unique challenges:
    a. Unique ethical tensions
    b. Lack of role clarity within multi-disciplinary teams
    c. Faces power imbalances
    d. Human resources/complaints processes do not consider needs of LLEW
7. Has unique needs when it comes to training, learning and development
8. Unique solutions to challenges that the mental health sector faces, and that consumer lived experience workforce face as a discipline.

Our framework



THE THREE CORE SECTIONS

This Framework is structured around three core sections: values and principles, scope of practice, and theories and knowledge, each of which plays a crucial role in defining and supporting the contributions of the consumer lived experience workforce.

Values and principles

Values and principles form the bedrock of who we are as consumer lived experience workers. This section defines the fundamental values that shape the approach and philosophy of consumer lived experience practice, including choice, connection, and human rights. It also details the principles that translate these values into actionable guidelines, ensuring that consumer lived experience workers operate with integrity and consistency in their daily interactions and decision-making.

This section was built upon new research conducted by consumer academics at RMIT, synthesised with a scoping of relevant sector publications to embed what the workforce has said about values and principles in the past.

Scope of practice

Scope of practice outlines the boundaries and responsibilities of consumer lived experience workers. This section presents key ways of working that guide the consumer workforce broadly and with a role-specific focus. This section contains information on supporting professional practice through discipline-specific supervision, communities of practice and cultivating reflective spaces. This section also outline's First Nations perspectives and guidance on diversity in practice. An outline of co-production completes the Scope of practice.

Together, these sections offer a guide for consumer lived experience workers and the mental health sector. They provide the necessary structure for value-driven, effective, and consumer-led service delivery, while also supporting the professional growth and development of individuals in critical roles within the mental health and wellbeing sector.

Theories and knowledge

Theories and knowledge present foundational concepts informing the consumer lived experience discipline. This section highlights key concepts that underpin practice, ensuring that consumer workers are grounded in past, present and emerging theories and knowledge. This section also outlines trainings, learnings and development frameworks that support the consumer lived experience workforce, including offerings developed in Victoria.

Implementation

There is further work to be done on the implementation of the sections of this Framework into our workforce's practices, including receiving feedback from the sector.

The consumer lived experience workforce

Roots in activism

Consumer lived experience work is grounded in claiming civil rights and social justice[44] and is founded on two parallel social events. One was the civil rights movements from the 1950s, 1960s and 1970s, when Black Americans struggled to gain equal rights. Simultaneously, other marginalised and oppressed groups also began to see how their experiences of oppression and struggles for equality were aligned, such as those fighting for gay and lesbian rights, women's liberation, and disability rights.

Consumer/survivors began to meet and share stories about the experiences they had when hospitalised, adopting a civil and human rights framework within which to view these experiences. Manifestos and newsletters sprang up such as Madness Network News[45] in the United States (US) that raised political and social questions around psychiatry. A collective movement grew demanding justice and rights.

THE AIMS OF THE CONSUMER MOVEMENT HAVE BEEN SUMMARISED AS:

In the mental health arena, the consumer movement seeks social justice through understanding mental illnesses in terms of human rights, the social suppression of difference, and treating differences through psychiatric diagnosis.[46]

Mutual self-help

The other influence on the consumer/survivor movement was mutual self-help groups. In these groups, people would provide one another with support. They were independently organised groups, unattached to formal services, non-hierarchical, engaged in awareness raising, and were explicitly political, with people sharing stories of care that had not met their needs.[47] Peer support promoted human and civil rights and alternatives to the medical model, based on the idea that giving help is self-healing, and that through being together, a sense of community of equals could be built. The principles underpinning this type of peer support would essentially become the values underpinning peer support as we know it today.

Our workforce today

Presently, there are designated consumer lived experience roles within community, public, private and peak body organisations. Consumer lived experience workforce members are employed across Victoria in rural and remote, regional, and metropolitan areas and in state-wide services.

Consumer lived experience roles exist at all levels of service delivery, leadership and policy initiatives, including consumer advisory groups that help steer the direction of mental health and wellbeing sector design, delivery and improvements. Consumer lived experience workers are present in almost all areas of the mental health and wellbeing sector including emergency departments, inpatient units, community outreach, leadership, tribunals and in settings where policy decisions are made.

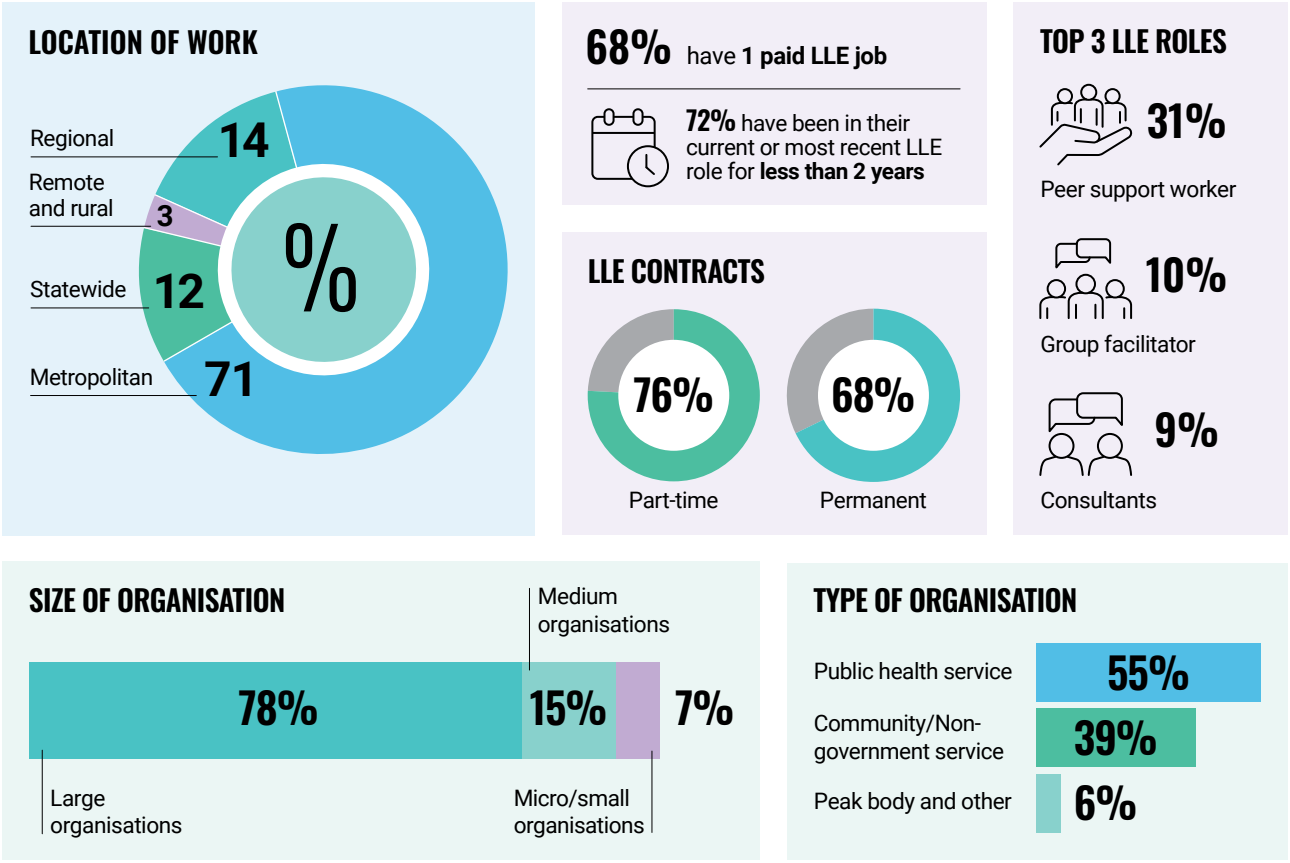
Consumer lived experience roles are diverse and ever evolving. The language and role titles that define consumer workers shift over time and can vary between services. Roles within the consumer lived experience discipline include peer workers, senior peer workers, consultants, advocates, managers, coordinators, educators, researchers, and policy advisors.

Consumer lived experience workers also hold specialist roles within the discipline. Some of the specialties that make up the workforce include youth, adults, older persons, eating differences, forensics, First Nations social and emotional wellbeing (SEWB) workers, and a lived experience of suicide, which is described by sector leads in the following quote.

"A lived experience of suicide is having experienced suicidal thoughts, survived a suicide attempt, supported a loved one through suicidal crisis, or been bereaved by suicide.[48]"

(Roses in the Ocean, 2024)

The consumer lived experience workforce is always evolving. As the sector, society and culture around mental health and wellbeing evolves, opportunities for new consumer lived experience roles will emerge.



Source: Lived and living experience individual survey (May – June 2022). https://www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives

Key concepts informing our collective knowledge

Concepts that describe our experiences give us tools to understand and talk to power and to advocate for ourselves and others. Our collective knowledge can also provide us with tools and language to understand experiences like discrimination, or why self-determination and choice are so important to many consumers. The key concepts are presented in alphabetical order.

Abolition

Abolition seeks to dismantle harmful mental health systems and promote alternatives that prioritise well-being and autonomy. Abolition involves two strategies: dismantling all oppressive structures, and at the same time, building new ways of being and doing. For abolitionists in the context of psychiatry, mental health laws are immoral, discriminatory and cause harm. Such laws ae embedded in interlocking systems of punishment like prisons. These systems of punishment disproportionately affect those already marginalised by poverty and trauma. Prohibiting the forced treatment and detention of diagnosed people requires political will and committed work on many fronts.[49] While abolition is about getting rid of systems that harm, it is also about creating community-led responses, based on informed consent.

The range of programs and practices already in place demonstrate that abolition is not 'just an ideal'. For instance, First Nations' activism for law reforms, community-controlled organisations and self-determination are examples of abolition leadership.

Body knowledge

Some consumer workers have talked about gaining a particular intuitive or bodily sense of when something is 'not right' or a sensitivity to 'power over' situations. This is often knowledge generated through having experienced loss of decision-making control, or trauma.

For example, we might have skills in knowing how to read environments, like whether a person is being straightforward, or being sensitive to situations of 'gaslighting' or other bullying.

Again, self-reflection, accessing discipline-specific supervision and being networked in with the broader consumer workforce and movement are important knowledge and practice supports.

Co-option

Co-option is a process by which a dominant group attempts to absorb or destroy anything believed to pose a threat to its ongoing power.[50] For example, we use it to describe the process of consumer workers' being absorbed into mental health services and no longer being able to practise in ways that are true to our values and principles. Peer work can be severed from its roots as a social justice practice and the value that peers can contribute to mental health system transformation can be lost.[51]

Consumer workers often face pressure to undertake tasks that are outside of their role functions.

This can arise particularly in clinical settings or where consumer workers are working in isolation. Engaging in consumer perspective supervision, checking in with other consumer workers, and engaging in self-reflection can help identify and resist co-option.

Discrimination

Understanding discrimination, oppression, stereotypical thinking and its impact on members of the consumer workforce as well as people using mental health services is fundamental to consumer workforce practice. Individual discrimination might take the form of attitudes like believing consumer workers are not as capable as others, or not socialising with consumer workers because they are not really seen as 'part of the team'.

Understanding some of these attitudes and behaviours can be very liberating because they can be put in a political context, and not a personal one.

Consumer workers might not be provided with flexible leave arrangements, or their abilities might not be trusted, resulting in excessive micro-managing.

Epistemic injustice

Originating in ethics more broadly, the concept of epistemic injustice[52] has recently been one of the most important and useful concepts for the consumer/survivor movement. It contains two parts: testimonial injustice is the process by which a hearer gives less credence to a teller because they belong to a marginalised group. In our context, consumer/survivors are already often thought not to be reliable, to 'lack insight' but in addition, the power of psychiatry constrains and silences ways of knowing, expressing, central to a person's sense of self.[53,54] From this suppressed position consumer/survivors' ability to speak and be heard on their own terms is compromised.

The second part of epistemic injustice is hermeneutic injustice, describing a situation where there are not yet social resources (i.e. words and concepts) for a marginalised group to explain and understand their experiences of injustice. This too is a very important concept for consumer/survivors and the consumer workforce because it provides us with explanatory tools.

Understanding the concept of hermeneutic injustice allows us to see how oppression experienced by marginalised groups can be hidden.

Understanding the concept of hermeneutic injustice allows us to see how oppression experienced by marginalised groups can be hidden. In our context, because the medical model is presented as 'true' it excludes other explanations people have for their distress, and it is difficult to point to treatment and detention without consent, for example, as human rights breaches because they are seen as natural and necessary in order to protect health and safety. Consumer/survivor scholars, however, have written extensively about ways that the dominance of the medical model deprives people of their own way of knowing and being in the world.

Working towards epistemic justice means advocating for anti-oppressive ways of working and continuing to use peoples' preferred language and concepts for their experiences. Using terms such as trauma, crisis, Madness, and distress, for example, are ways that consumer/survivors have reclaimed language for their experiences that are not pathologizing and do not medicalise human experiences.

Epistemic violence

An adjacent concept, originating from postcolonial studies, is 'epistemic violence' which refers to the ways groups are disqualified as legitimate knowers on a structural level. When a group's worldviews, knowledge, and ways of being are denied, they can be de-humanised and rendered invisible. To speak and be heard from this position is not possible.[55]

For example, historical constructions of First Nations peoples' discredit their knowledge and ways of being as 'primitive' and white western knowledge as 'sophisticated.'

When a group's worldviews, knowledge and ways of being are denied, they can be de-humanised and rendered invisible.

For consumer/survivors, epistemic violence occurs when the only available identity is one of illness, where we are disordered, unpredictable, dangerous, or incompetent. From these fear-based responses our ways of knowing are dismissed. If we encounter such 'sanist' attitudes in our workplaces, either towards ourselves or others, we can creatively question how we might achieve epistemic justice on a systemic level, and who our allies might be.

Experiential knowledge/expertise

Unlike third person 'objective' knowledge, consumer perspective has been described as 'first' person, or experiential knowledge or expertise.[56] Consumer perspective work is conceptualised as a discipline in its own right, with its own distinctive principles and values. It has been described as founded on a commitment to freedom and social justice, and emphasising change.[57]

Having a 'lived experience' on its own is not the same as intentionally using lived expertise in our work, in a designated consumer perspective role, where lived expertise is the lens through which we view our work and make decisions.

Our advocacy is often directed at making social systems fairer and more accessible.

THE CONSUMER WORKFORCE, FOR EXAMPLE, DRAWS ON THE COLLECTIVE CONSUMER PERSPECTIVE KNOWLEDGE BASE:

> As the lived experience workforce evolves, it is essential to be grounded in the consumer movement's history and consumer/survivor culture in providing the foundation and values of lived experience work within a civil rights and social justice framework.[58]

(Roennfeldt and Byrne, 2021 p. 1448)

Our work is performed within a clinical paradigm which can cause tensions because our approach is based on unique values, principles and practices, but is required to operate within mental health service systems that can be at odds with these approaches. For instance, peer work is founded on mutuality, transparency and being responsible for our own part in relationships, but the policies and practices of clinical services may expect consumer workers to do assessments, or to be in clinical review meetings without consumers' involvement where it can be difficult to refuse to comply.

Human rights

Putting aside the question of whether or not this can ever be justified, is the fact that it happens and causes harm. To be working in systems where this is possible can cause great ethical tension for consumer workers, as we can feel implicated, or as though we are powerless to make the changes we would wish to see.

Human rights are of concern to the consumer workforce because they can be jeopardised in public mental health services.

Labelling

Since the earliest days of the consumer movement, challenging the psychiatric diagnostic system and moving away from the prevalence of deficit/illness models has been fundamental.

The process of labelling by the psychiatric system can lead to assumptions of incompetence and narrows the ways people have for making sense of their experiences.[59, 60, 61]

In marked contrast, peer workers, for example, do not diagnose, nor do they adopt a clinical worldview, or impose a worldview onto another person. They would, however, seek to understand the worldview of the person they work with.

Mad studies

Originating in Canada, it is becoming increasingly influential as a global field of study. It rejects a bio-medical approach to understanding experiences of distress/madness, instead proposing a framework of 'madness'[62] and sharing similar theoretical similarities to disability studies and critical social theory. The first issue of the International Journal of Mad Studies was launched in 2021.

Mad Studies merges activism and scholarship, founded on lived experiences, culture and politics of people identifying as Mad, neurodiverse, consumer/survivors etc.

Othering

Rather than an empathetic response, othering is a fear based or disgust-based response. Othering is often linked to de-humanisation, where one person treats another like a non-person, or as less than human, not entitled to agency or respect.

People who are diagnosed can be treated as though there is something wrong with the way they know things, and how they are in the world, and how they make meaning.

Pathologisation

Pathologisation describes the way that once diagnosed, a person's behaviour or beliefs are seen through an illness lens.

For example, interest in spiritual healing could be interpreted as a delusion, voice hearing as psychosis that has no meaning, rather than a trauma response, and a person who does not think they have a disease can be labelled as lacking insight and incapable of making decisions.

These processes can lead to de-humanisation in that a person is viewed as a disease rather than as a person in need of support. Members of the consumer workforce may feel that they can't show any emotion at work, in case they are thought to be "too vulnerable", or they might feel they have to work twice as hard to be respected. Or they might experience colleagues doubting their decision-making due to negative opinions about what the consumer worker is capable of in their job.

Non-hierarchical

The consumer workforce tends to prefer shared decision-making models over hierarchical ones.[63] This might mean working within teams, having regular check-ins and making democratic decisions.

Favouring democratic decision-making can be traced to having experienced 'power over' by others, not wishing to replicate this, and highly valuing mutual relationships.

Nothing About Us Without Us

With its origins in the South African disability rights movement[64] and then becoming a global catchcry for people with disabilities, the activist demand was for a role in developing policies and laws as well as decisions impacting on an individual level. Significant activism by people with disabilities moved the needle from a 'charity case', paternalistic decision-making model, to one where no decision should be made without the person. This catchcry was influential for the consumer/survivor movement, supporting the idea that we should be involved in all decisions affecting us, at law, policy and practice levels.

This one principle perhaps best describes the 'north star' of consumer work and what we advocate for because it is founded on the self-determination of individuals and wider collective. It is also a reminder that our work is always political.

Self-determination and choice

Due to experiences of being denied the right to make our own decisions, self-determination is very highly valued.[65]

Our values of freedom and emancipation are closely tied with self-determination and with resisting others' making choices on our behalf, which includes non-consumers deciding what our workforce needs.

As members of the consumer workforce, we advocate for workplaces that are safe and allow us to work according to our discipline's values and principles, and we also advocate for the self-determination of others.

Social justice/anti-oppression

Due to experiences of discrimination, prejudice, social disadvantage and other injustices, and in common with many other marginalised groups, our advocacy is often directed at making social systems fairer and more accessible. Exposing discrimination and human rights violations in the mental health field and more broadly is central to consumer perspective.

Through our work we advocate for a more equitable system, challenge the social conditions of trauma, and creates spaces for change.

The social model of disability

Under this model, the disability is the extent to which the broader environment can either enable or get in the way of how people with disabilities prefer/want to live. This model assumes that all people are equal before the law, but that people with disabilities might need assistance in order to achieve equity.

Rather than conceptualise disability as an individual medical problem needing to be 'fixed', the focus is on social attitudes, laws and policies and how they interact with 'people with disabilities'.

This model is embedded in the United Nations Convention on the Rights of Persons with Disabilities.[66] The social model of disability has had an impact on the development of the consumer/survivor movement and our knowledge. It has been helpful in making the case that social determinants have an impact on distress, and vice versa.[67] This framing of disability has been useful to the argument that our autonomy and decision-making should be respected the same way anyone else's would.

Solidarity

The consumer movement offers solidarity, and pride in our history of surviving discrimination, and our history of advocating for ours and others' rights.

To be networked into a social movement is to belong, to be understood and be held steady in common values and principles, even when there may be fundamental disagreements.

As is the case with marginalised groups there is strength in numbers, and like all movements, we are passionate about our aims.

This solidarity gives us our shared knowledge base.

VALUES AND PRINCIPLES

This section presents the fundamental beliefs and ethical standards that guide consumer workers in their roles.

These values and principles provide a benchmark for consumer workers to navigate complex situations, make ethical decisions, and contribute to a supportive environment that honors the human rights and self-determination of consumers.

The values and principles underpinning the consumer lived experience discipline form the cornerstone of effective and compassionate practice:

- Values are broad, guiding beliefs that shape the overall approach and ethos of practice
- Principles are specific, actionable guidelines that detail how values are to be translated into practice and decision-making.

The values and principles are a synthesis of sector surveys undertaken by RMIT and what the relevant grey literature says about consumer lived experience workforce values and principles. In our scoping and synthesis, we sourced values and principles that are unique to the consumer lived experience workforce.

Values

1. Consumer choice and freedom
2. Self-determination
3. Human rights
4. Non-coercion
5. Connection
6. Mutuality and reciprocity
7. Transparency
8. Authenticity

Descriptions

Consumer choice and freedom	"Acknowledging and respecting each person's choices, dignity of risk and boundaries. Acknowledging that the person is the expert of their own experience[s]." (Bryne, Wang, Roennfeldt, Chapman, Darwin, Castles, Craze, & Saunders, 2021, page 22)[68]
Self-determination	"An individual or group having the autonomy to shape one's life in the present and future in all areas including personal, political and cultural aspects. Where oppression exists, upholding self-determination means seeking to remove barriers." (CAP team)
Human rights	"Knowledge of the consumer movement as a response to the history of social injustice and discrimination towards people with lived experience and that the Consumer Lived Experience work is connected to the human rights movement." (Roennfeldt, Chapman, & Byrne, 2024, page 46)[69]
Non-coercion	"Not engaging in actions that undermine a person's free will, bodily integrity, or consent." (CAP team)
Connection and empathy	"Holding relationships at the centre of all Consumer work, recognising our connection to others, nature, animals, and spirituality." (Roennfeldt, Chapman, & Byrne, 2024, page 40) "Empathy refers to understanding another's experience from a point of common experience and genuine connection." (Roennfeldt, Chapman, & Byrne, 2024, page 62)
Mutuality and reciprocity	"Mutuality refers to being in a relationship with another person where both people learn, grow and are challenged through the relationship. It is also described as sharing responsibility in relationships." (Roennfeldt, Chapman, & Byrne, 2024, page 62)
Transparency	"Availability of full information required for collaboration, cooperation, and decision-making without hidden agenda" (CAP team)
Authenticity	"Authenticity means bringing your true self to the work while knowing your boundaries and limitations. A willingness to work in developing our own identity and support others in developing theirs too. It's about being genuine and honest, including what we can and can't do. Working with deliberate attentiveness and responsiveness because we have been there too." (Mental Health Commission, 2022, page 16)[70]

Principles

1. Lived experience as expertise
2. Commitment to systems change and social justice
3. Holds space for different world views
4. Recognises the importance of equity, equality and diversity
5. Addresses power imbalances
6. Knowledgeable of the impacts of trauma
7. Understands distress as a social issue
8. Safeguards choice

Descriptions

Lived experience as expertise	"Working in a way that is informed by the body of knowledge created by the collective Consumer Lived Experience community and the ability to apply that knowledge in the work context." (Roennfeldt, Chapman, & Byrne, 2024, page 48)
Commitment to systems change and social justice	"Consumer workers seek to drive system changes to improve the human rights of consumers accessing services. Consumer workers expose where human rights breaches are present." (CAP team)
Holds space for different world views	"A tenet of Lived Experience work is the ability to hold space for and respect different views, allowing for multiple perspectives." (Byrne, et al., page 13)
Recognises the importance of equity, equality and diversity	"Understanding the impact of social justice/inequity on identity and opportunity e.g race, culture, sexual orientation. Recognising that equal access to resources and support is an important factor in everyone's recovery (and healing)." (Roennfeldt, Chapman, & Byrne, 2024, page 63)
Addresses power imbalances	"Understands the impact of interpersonal power within a hierarchical system and how it impacts consumers' lives. Resists coercion over others." (CAP team)
Knowledgeable of the impacts of trauma	"Acknowledges the impact and prevalence of trauma, negative experiences and loss of control and power. Emphasises the need for physical, psychological and emotional safety." (Queensland Health, 2021, page 14)[71]
Understands distress as a social issue	"Distress is a social issue that can stem from poverty, discrimination, marginalisation and isolation. Distress should be addressed within the context of wider harms" (CAP team).
Safeguards choice	"Recognises that individuals can define what recovery/healing means to them, and each person can create a life that is meaningful for them." (Queensland Health, 2021, page 14)

SCOPE OF PRACTICE

A scope of practice defines the boundaries within which a professional operates, highlighting what is in and what is out of our discipline's scope. It establishes the limits of roles, ensuring that a discipline's practice remains within the framework of its expertise.

A well-defined scope of practice serves to protect both the worker and the individuals they support, ensuring that services are delivered effectively. It also facilitates clarity and consistency across the profession, enabling workers to work in alignment with established standards and guidelines.

This section defines the scope of practice for workers in the consumer lived experience discipline in Victoria, outlining the key responsibilities, skills, and boundaries essential to undertaking their roles. This section also outlines some key responsibilities of organisations to support the growth and professional development of consumer lived experience workforce members.

In and out of scope

What is in and what is out of the scope of consumer lived experience work

In Scope	Out of Scope	Examples
Working from a consumer perspective	Working within the medical model	**In scope:** Listening to and talking with a consumer about their experiences and what might be helpful. **Out of scope:** Encouraging a consumer to do to what clinical staff tell them to do.
Working with the value of **'consumer choice'**	Contributing to the coercion of a consumer	**In scope:** Listening to a consumer talk about how they feel about their diagnosis. **Out of scope:** Focusing only on a consumer's diagnosis.
Working in line with the principle **'holding space for different worldviews'**	Patholigising a consumer because of their views	**In scope:** Listening to and respecting a consumer's beliefs. **Out of scope:** Being 'worried' because a consumer is expressing beliefs that you have never encountered.
Working in line with the principles **'safeguarding choice'**	Ignoring consumer principles	**In scope:** Supporting a consumer to self-advocate for their choice in medication. **Out of scope:** Trying to convince a consumer that taking medication will 'cure' them.
Ways of working in line with a consumer perspective	Not working in line with consumer perspective ways of working	**In scope:** Provide time and space for a consumer to talk about trauma. **Out of scope:** Shutting down conversations about trauma because you are 'worried' it will 'trigger' the consumer.
Role-specific ways of working in line with a consumer perspective	Doing tasks outside of the role	**In scope:** Offering to support a consumer during a clinical assessment. **Out of scope:** Undertaking a clinical assessment.

Ways of working

Ways of working demonstrate the ways in which we do our work as consumer lived experience workforce members. Our ways of working are based on our values and principles and underpinned by our theories and knowledge. In addition, our ways of working have been developed through consumer lived experience workforce members working in the system to effect change over decades.

The CAP team co-designed the following section with the EKG and a First Nations perspective session. We have jointly identified ways of working relevant to the entire workforce.

Ways of working are structured into three levels: entry level, experience level, and discipline expertise level. The entry level represents the foundational skills and knowledge required for individuals new to the field, focusing on basic competencies and understanding. The experience level builds upon this foundation, incorporating more advanced skills and a deeper grasp of complex concepts. Finally, the discipline expertise level encompasses a high degree of specialisation and knowledge, where workforce members are expected to exhibit advanced sector knowledge, embedded innovation, and demonstrate leadership within their area of expertise.

This tiered framework supports a clear pathway for professional growth while maintaining high standards of practice at every stage.

Entry level ways of working

Prerequisites				
Holds a consumer lived experience perspective	Holds a consumer live experience perspective and intentionally brings it to their role	Provides an alternative experience to medical models	Understands that the mental health system can harm consumers, although not all experiences are harmful	Maintains a flexible approach to change
Our practice is human rights based	Willingness to develop an understanding of human rights for consumers	Looks at all aspects of person including their spiritual, emotional and physcial self	Upholds the dignity of risk and works in a person-directed way	Is aware of workplace discrimination
Experience-based learning				
Upholds consumers' voices	Elevates and empowers the voices of consumers	Uses inclusive and strength-based language that reflects lived experience perspectives	Holds space and is respectful of difference worldviews	Has an understanding of power imbalances and the need for system change
Understands the impacts of trauma	Understands that trauma should not be pathologised	Is aware of systemically-derived trauma	Understands that consumers are highly represented as trauma survivors	Understands that every person has a unique healing journey
Understands barriers to inclusivity	Understands cultural diversity and different world views	Has an understanding of marginalisation and intersectional identities	Respects First Nations' ways of knowing, being and doing	Understands implicit biases and privilege
Organisational responsibilities				
Is supported to put lived experience into practice	Is supported to attend IPS training and incorporate IPS principles into their work	Has access to external lived experience supervision	Is supported to access time with lived experience colleagues and is involved in co-reflective spaces	Is encouraged to work in a way that promotes self and collective care within work hours

Consumer Workforce Lived Experience Discipline Framework (Victoria) 2024

Experienced level ways of working

Prerequisites

Well developed consumer lived experience perspective	Has knowledge of the roles and disciplines within the LLEW workforces	Understands the theories and knowledges behind alternative experiences to medical models	Understands that the mental health system can contribute to the institutionalisation of consumers	Identifies when there is pressure from services for co-option or role drift
Our practice is human rights based	Advocates for the human rights of consumers to be upheld at all times	Understands how human rights breaches impacts peoples' health and wellbeing	Has an understanding of ethical decision-making	Is aware of options to adress discrimination in the workplace

Experience-based learning

Upholds consumers' voices	Advocates for the voices of those most impacted	Adresses the use of dehumanising or exclusionary language	Advocates for system change that is needed in order to preference the voices of consumers	Supports others to step into their strengths
Understands the impacts of trauma	Understands the impact of trauma to health and wellbeing	Understanding system trauma including poverty, discrimination, colonisation, racism, gender-based violence, incarceration	Understands how trauma can compound into disadvantage	Implements and advocates for approaches that support healing in a person-directed way
Understands barriers to inclusivity	Advocates for the inclusion of people with diverse cultures, genders, sexualities and disabilities	Applies an awareness of intersectionality in their ways of working	Develops knowledge about the Social and Emotional Wellbeing framework	Challenges implicit biases when they arise in themselves and others and is aware of privilege and "othering"

Organisational responsibilitiess

Is supported to put lived experience into practice	Undertakes training and professional development relevant to the role	Is knowledgeable about consumer perspective supervision and may be able to provide supervision	Can provide co-reflection and share experience and knowledge with other lived experience staff	Is encouraged to build leadership skills and attend leadership training	Proactivley implements self and collective care strategies within work hours

Consumer Workforce Lived Experience Discipline Framework (Victoria) 2024

Discipline expertise ways of working

Prerequisites

Has consumer lived experience discipline expertise	Develops and maintains relationships with other LEW networks	Shares knowledge of the consumer movement with the workforce	Can manage projects that include multiple roles in the sector	Minimising institutionalisation; drives de-institutionalisation	Updates knowledge and is informed about new ways of working
Our practice is human rights based	Advocates for services to be human rights compliant	Advocates for the lived experience knowledge to provide alternative to medical model		Supports workforce when broader human rights matters impacts peoples' health and wellbeing	Understands systemic issues without losing sight of what's happening on the ground

Experience-based learning

Upholds consumers' voices	Removes barriers so that the voices of those most impacted can be influential	Drives cultural changes in the organisation to be consumer-centred	Develops or updates organisational policies and procedures to embed consumer values and principles	Leads co-production and can develop and lead organisational change process
Understands the impacts of trauma	Challenges a deficit-based view of people who have experienced adverse events	Advocates for First Nations consumers to work with workforce members with a SEWB lens	Understands trauma can resurface and can support workforce members	Can teach about the impacts of trauma and person-directed approaches to healing
Understands barriers to inclusivity	Advocates for continued improvement in organisational cultural safety	Advocates for the needs of culturally diverse workers to be met	Educates others on diversity and intersectionality and how they are applied in practice	Develops policy changes and advocates for additional funding to support members of the workforce carrying cultural/colonial loads

Organisational responsibilitiess

Is supported to put lived experience into practice	Can develop lived experience training through identifying gaps and building on what already exists	Can provide lived experience supervision in a way that meets the diverse needs of workforce members	Has the skills to develop co-reflective spaces and support lived experience staff to participate	Can facilitate succession planning, carrying expert knowledge into new generations	Has established self and collective care strategies to support staff during work hours

Consumer Workforce Lived Experience Discipline Framework (Victoria) 2024

Role-specific ways of working

Incorporating role-specific ways of working provides essential clarity within the consumer lived experience discipline. This section was co-produced by members of the EKG.

The EKG identified several key responsibilities for specific roles within the sector. However, the group recognised that the consumer lived experience discipline is ever evolving, and as such the specifications of roles and duties cannot be encapsulated in a static document. This acknowledgment highlights that consumer lived experience work should remain responsive to the needs of consumers and maintain a flexible approach to change.

Consumer lived experience work should remain responsive to the needs of consumers and maintain a flexible approach to change.

Direct service roles – peer support work, consumer group facilitators

Entry level	Experienced level	Discipline expertise
Engages in deep and active listening and holds space for the consumer's needs	Purposefully uses lived experiences to support others to move through challenges and celebrate successes	Connecting consumers to the consumer movement if they are interested by providing resources and oral history
Works with consumers rather than doing things to or for them	Accompanying consumers to assessments, tribunals and legal proceedings and providing support throughout the process	Provides consumers with alternative approaches to healing than the biomedical model
Walks alongside consumers while they navigate their journey	Supporting consumers to access the community, social life, wellbeing and vocational pursuits	Informs consumers of their human rights, their rights within the service and under the Mental Health and Wellbeing Act
	Assists consumer to advocate for their choices to be upheld	

Leadership roles – managers, coordinators, team leaders

Entry level	Experienced level	Discipline expertise
Utilises expertise to support the voices of those most impacted	Leads evaluation and sector change processes and has knowledge of co-production and consumer-led initiatives	Develops knowledge of new pieces of consumer-led work, development programs, and research that can help to define or grow the consumer lived experience workforce
Provides education to the sector on consumer lived experience and consumer perspective	Embeds consumer lived experience perspective in policies and procedures	Translates lived experience-led research back into the sector
Seeks out opportunities to involve consumers in systems change processes	Can review and apply relevant legislation and policies	Is knowledgeable of the Royal Commission into Victorian Mental Health System and is part of implementing its recommendations
	Critiques system practices to bring about positive change	

System change – consultants, researchers, educators and policy roles

Entry level	Experienced level	Discipline expertise
Models the use of consumer perspective, values and principles, and ways of working within role	Assists team members to develop an understanding of professional boundaries and the importance of self and collective care at work	Educates the organisation on consumer lived experience work and what the scope of consumer lived experience work is and is not
Advocates to non-designated consumer lived experience staff about the value of consumer work	Develops and maintains relationships with other LLEW networks	Grow and develop the LE workforce, advocates for staff to have external LE supervision, attend training, receive pay rises
Provides leadership and support from a consumer perspective to consumer lived experience staff	Actively works to minimise opportunities for co-option or role drift	Supports change management processes
	Advocates for consumers at a systemic level	

Supporting professional practice

This section explores the supports available to consumer lived experience workers to further develop professional practice, including discipline specific supervision, communities of practice (CoP) and co-reflection spaces.

Consumer perspective workers are often working in isolation or are the minority discipline perspective in a clinically dominated workforce. Ongoing discipline specific support is essential for the sustainability of the consumer lived experience workforce.

> **Mentoring, peer support and opportunities for talking with other consumer workers to develop 'reflective practice' and to support people in doing consumer perspective work were considered important hallmarks of the consumer workforce culture.**[72]

(Bennetts et al, 2013 p. 319).

Consumer perspective supervision

Discipline specific supervision is essential for all disciplines and is an invaluable component of professional practice, workforce development and worker wellbeing.

Consumer perspective supervision (CPS) provides a space to reflect on one's work, whether that be direct service, leadership or system change roles. CPS provides an opportunity to consider our work and its alignment with consumer perspective values and principles. It enables reflection on our work including developing strategies to work with the complexities that arise in a system that privileges the biomedical model.

Without regular discipline specific supervision, a consumer worker may not be able to reflect on how their work aligns with consumer values and principles. A consumer worker may find themselves undertaking work that is out of scope and of a clinical nature, which is known as peer drift.

There are nine values informing CPS: self-determination, connection, mutuality, lived experience as expertise, responsibility, authenticity, transparency, hope, and curiosity.[73]

CPS can be offered internally through supervisors employed by the organisation, or through supervisors external to the organisation. However, access to an external supervisor is viewed as best practice. External supervision provides an unbiased space where consumer workers can reflect and debrief without fear of adverse action or negative consequences. It is important to distinguish between CPS and line-management, which is more focussed on operations and HR-related matters. It is best practice for discipline specific supervisors to be distinct from line managers.

THE FUNCTIONS OF CONSUMER PERSPECTIVE SUPERVISION

> Consumer perspective supervision provides unique functions for the workforce, including providing a safe space where challenges and tensions can be identified and shared, and where the worker can experience empathy and validation. It's a space where doubts can be explored, and confidence built. Challenges posed by work contexts can be productively explored and debriefing provided. Supervision sessions can help with worker isolation, safety, self-care, as well as developing leadership, and providing opportunities for exploring innovative approaches to consumer perspective practice.

THE CONSUMER PERSPECTIVE SUPERVISION RELATIONSHIP

> The supervisor creates and maintains a reflective space for the supervisee to safely bring their concerns. Consumer perspective is the lens through which these concerns are examined. Additionally, the supervisory relationship is itself characterised by the values and principles underpinning consumer work, for example, the relationship is founded on the concept of mutuality, enacted through the exchange of life experiences, skills and knowledge that each person brings.

Source: Victorian Mental Illness Awareness Council & Centre for Psychiatric Nursing, 2018.

Communities of Practice

A community of practice (CoP) is a space where a group of individuals within a profession come together in ongoing spaces to share learning, build knowledge and collaborate on tasks that are important to the group. Group members share resources and experiences, including discussing challenges, reflections and innovations. Communities of practice are important spaces for the consumer lived experience workforce for several reasons:

Shared learning and growth: A CoP provides a space for consumer lived experience workers to share insights, experiences, and resources. This collective knowledge supports professional growth and encourages innovation in approaches to consumer perspective work.

Mutual support: Members of a CoP can offer emotional and practical support to one another, helping to mitigate feelings of isolation that often arise in this line of work. By sharing challenges and successes, individuals can find support and encouragement from peers who understand the unique experiences of the workforce.

Reflective practice: Regular interactions within a CoP can create opportunities for reflective practice. This allows members to discuss dilemmas and celebrate successes.

Navigating challenges: Working in mental health and wellbeing spaces often involves navigating complex ethical dilemmas. A CoP provides a space for discussing these challenges and seeking guidance from peers who have faced similar situations.

Strength and advocacy: A CoP can amplify the voices of consumer lived experience workers, advocating for rights and the importance of their perspectives in multi-disciplinary teams. This solidarity can lead to greater recognition and integration of consumer perspectives in policy and practice.

Cultural competence: Engaging in a diverse CoP helps build cultural awareness and sensitivity, allowing members to explore different worldviews and approaches to care.

Supporting new workforce members: CoPs can be a vital tool and resource for incoming consumer lived experience workforce members to connect with the movement by meeting with and learning from experienced knowledge holders.

Working in mental health and wellbeing spaces often involves navigating complex ethical dilemmas.

"I have found one of the most useful parts of reflective spaces with respected consumer workers is when they are **grounded in the movement and collective consumer perspective** and are able to critically reflect of practices."

"Mutual support is an essential part of **protecting and nurturing** the complex needs of the LEW. It provides an opportunity for the lived experience practitioner to **connect with community, receive and provide support, and to have a voice in further development and growth of the broader Lived Experience Workforce.**"

"Mutual support is: "Important to consumer LEW not to feel isolated as some work in outlying teams, rural areas and **often are the only LEW so mutual support is important so they don't feel alone.**"

"One of the key ingredients in authentic peer work is relational engagement. The ability to connect with others, share wisdom and connect through vulnerability is essential. Isolation is harmful to all humans, and just as much for peer workers. **Working together and having places to connect increases safety and allows for improved practice over time.**"

"Understanding of mental health and wellbeing services that **connection with the LEW across the state and nationally is very important.** It is not just the daily work we do within our services, but the connections we have to our community and colleagues that can **help us through difficult and challenging times.**"

"Knowing that there is a network of peers who understand and share similar experiences can provide **strength, resilience and support during challenging times.** Through mutual support consumer workers can **share innovative ideas and effective practices.**"

Source: The above quotes were provided by members of the consumer lived experience workforce in a sector survey distributed by the CAP team in July – August 2024.

Reflective spaces

Finding time to meet with peers and talk, connect and reflect is vital for the wellbeing of workforce members individually and collectively.

Consumer lived experience workers often face distressing situations that resonate with their past experiences, and wellbeing can be impacted without the space to reflect with peers in a supportive environment. Peer-to-peer interactions provide an opportunity for consumer lived experience workforce members to reflect on injustices they have witnessed or endured, creating a space of mutual support and understanding.

Informal time for connection encourages the exchange of skills and knowledge, allowing consumer workers to grow and learn collaboratively. Given that consumer lived experience workers often operate in isolation or in smaller numbers compared to other disciplines, these reflective spaces become essential for informal reflection on practice. They serve as a platform for discussing dilemmas, celebrating successes, and embedding learnings from consumers.

Engaging in these spaces can be either scheduled or spontaneous. Managers and workplaces should encourage consumer lived experience workers to see out time for peer-to-peer connection and reflection.

Peer reflective spaces should be relational and utilise consumer lived experience approaches, holding space for understanding across diverse worldviews. Engagement is collaborative, with feedback sought by invitation and provided with an awareness of the different roles and contexts within the workforce.

These reflective spaces help prevent opportunities for co-option and role drift to develop in the workplace, help workers adapt to evolving practices in real time, and reinforce the importance of community and connection among consumer lived experience workers.

Informal time for connection encourages the exchange of skills and knowledge.

"One of the most important parts of engaging with other consumer workers is **the ability to stay grounded in both peer values and the wider community movement.** Peer drift happens far too often and this can be avoided by spending time with other LLEW to reinforce good practice and safety."

"**Supporting connection for consumer workers is vital.** Isolated consumer workers are more likely to experience co-option and peer drift and psychological harms, especially in clinical environments. This can also mean it is harder to focus on **rights and self-determination** which can have direct negative effects for consumers using services."

"Mutual support is what we do, **we grow and learn from each other.** Not one person needs to hold the answers. **We are best placed to understand each other.**"

"Mutual support is not only a vital salve in **addressing peer drift and minority workforce challenges**, it is also necessary in a more general sense with regards to addressing vicarious trauma and **the ongoing confidence and skill development of the LEW.**"

"Without the ongoing mutual support of other consumer workers, I would not have been able to grow into the worker I am today. I would not have learnt about the need to keep **grounded in the consumer movement** and to discern when I was or wasn't working within the consumer perspective. Ongoing mutual support allows me to continue in this work."

"Mentoring, peer support, and reflective practice **increase the quality of service.** Talking with peers and mentors **provide emotional and professional support**, and experienced mentors can share insights and practical advice that is invaluable for newer workers."

Source: The above quotes were provided by members of the consumer lived experience workforce in a sector survey distributed by the CAP team in July – August 2024.

First Nations perspectives

The impact of historical injustices on First Nations people is profound and far-reaching. To drive genuine and transformative change, it is essential that our literature and practices acknowledge these historical harms. Without a deliberate and informed acknowledgment of First Nations peoples and their diverse perspectives, we are likely to perpetuate the very harms we aim to address.

The mental health system in place today was introduced over the top of practices of mental health and wellbeing care that existed on this land long before colonisation. These pre-colonial practices were deeply rooted in First Nations cultures and traditions, offering a unique and valuable approach to mental wellness and justice. It is therefore crucial that mainstream mental health and wellbeing care practices are designed and implemented with an awareness of and respect for these traditional practices. Failure to do so not only risks marginalising First Nations healing methodologies but also contributes to the erasure of their cultural significance and historical contributions to the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples.

Our research and consultations with First Nations academics and lived experience workers have revealed a significant gap in the representation and integration of First Nations roles within the sector. To address this gap, we have developed this section to illuminate and prioritise the unique perspectives and insights of First Nations lived experience workers.

Working from a First Nations lens often means working from a social and emotional wellbeing perspective. The Social and Emotional Wellbeing (SEWB) Framework can sit alongside consumer perspective ways of working, with many points of intersection, however, the uniqueness of the SEWB Framework should be acknowledged and is discussed in this section. Not all First Nations lived experience workforce members are employed in designated or identified roles. This section of the Framework aims to address the needs of all First Nations lived experience workers, including those in formal identified positions as well as those in other roles. Additionally, it seeks to support the mental health sector staff who work alongside First Nations lived experience staff and engage with First Nations consumers.

This section aims to enrich our understanding and practice, ensuring that the Framework is not only comprehensive but also inclusive of the rich cultural and experiential knowledge that First Nations people and communities bring to the field. By explicitly addressing these issues and integrating First Nations perspectives, we hope to generate a more equitable and effective approach to lived experience work that honours and incorporates the vital knowledge of First Nations people and communities.

Aboriginal and Torres Strait Islander lived experience workers have proudly and humbly shared their input whilst on Walkabout throughout this document.

First Nations working group

A yarning session was held for the First Nations working group and the below quotes were verbatim from the discussions. This highlighted the ongoing impacts of colonial harms and historical harms that have occurred and continue to occur impacting First Nations LLEW.

"Deaths in custody are not held to account"

"I'm not safe and I don't feel safe"

Fears of dying in custody - "anything can happen to me"

"Playing God"—harms enacted by people with privilege

"A lot of these systems, once you're in you're dead"

"Close The Gap is not working—it is keeping us as second-class citizens—we are statistics"

"No accountability from leaders on the harms they cause"

"Colonisation was heavily influenced by coercion, coercive practices trigger this living history"

"Lack of accountability is triggering - people in power say things that are not OK and no accountability is held"

"Coercion triggers all historical harms within the present day"

"The rape of our women"

"Coercing lateral violence"

"Burying history—not telling the truth even today"

"Lying—agreements that were not upheld"

Social and Emotional Wellbeing Framework

The Social and Emotional Wellbeing (SEWB) Framework was designed to deliver strength-based, holistic, and culturally sensitive care aimed at improving health outcomes for Aboriginal and Torres Strait Islander peoples. It encompasses seven core domains: connection to country, spirit and spirituality, body, mind and emotions, family and kinship, community, and culture.[74]

This framework not only emphasises the strengths of having a strong cultural identity but also considers the social, political, and historical factors that can influence an individual's wellbeing. By addressing these challenges, SEWB cultivates a supportive and cultural environment that enhances quality of life and promotes positive community relationships.

There is recognition that when implementing SEWB/cultural care from a lived experience perspective there may be adaptions to the language and practices that may differ from traditional lived experience workforce approaches and there needs to be allowances made for this.

Importantly, SEWB practices should only be conducted by First Nations SEWB workers or from First Nations-identified roles, as they reflect cultural knowledge and practices that have existed for 65,000 years. It is crucial for all sector workers to be educated in these culturally informed practices to effectively support Aboriginal and Torres Strait Islander staff members and consumers.

SEWB Diagram adapted from Gee et al., (2014)

First Nations knowledge

Intersectionality

Intersectionality plays a key role in understanding the experiences of Aboriginal and Torres Strait Islander peoples. In recognising a persons' journey as an individual experience there are identities of intersectionality that need to be considered. There are some of the layers that make people who they are – Rainbow Mob, gender diversity, diversity of experience (Stolen Generations), physical health outcomes, suicidality in oneself and in family. The pressures that are often faced are compounded by 250 years of systemic oppression, which has already placed them in a state of trauma. This additional psychological and spiritual burden can exacerbate their difficulties, leaving them to navigate new and challenging situations without adequate guidance or support.

Sharing stories

The act of sharing stories not only preserves culture but also highlights the importance of creating a narrative that can either uplift or harm individuals, reminding the workforce of their significant role in this process.

The rights to spiritual beliefs and faith

The right to practice spiritual beliefs through culture and other identifying faiths needs to be considered. For many Aboriginal and Torres Strait Islander peoples, connecting with spirit often correlates to a strong connection to land which is fundamental to their wellbeing as emphasised in the SEWB Framework. A healthy relationship with the land is directly linked to individual health; when the land suffers, so do its people.

Self-determination

Self-determination is recognised both locally and internationally as a human right for Indigenous peoples. It is essential for promoting safety and wellbeing across various aspects of life with an internationally recognised right to self-determination which includes choices around healthcare.[75]

A healthy relationship with the land is directly linked to individual health

Cultural safety

First Nations workers are not safe if their community is still being harmed by the mental health system. There needs to be recognition that for all First Nations workers within the lived experience space that they are or have been consumers impacted by the system and still see those harms within their communities.

We need to be working in culturally responsive workplaces. Cultural safety is everyone's responsibility. It is everyone's responsibility to be educated and understand that First Nations people have their own practices that take precedence over Western practices.

Acknowledges historical harms.

Understands the diversity within First Nations communities.

Understanding cultural practices around communication, especially non-verbal communication. This could include not making eye-contact, expressive body language, the concept of shame (the false shame).

Provides comprehensive cultural competency training.

Understands that workers can be carrying trauma that can be triggering by working in the mental health sector.

Cultivates an environment where everyone feels safe expressing themselves and advocating for their needs to be met.

A CULTURALLY RESPONSIVE WORKPLACE

Highlights the importance of connection to culture.

Makes allowances for cultural responsibilities.

Does not place cultural or colonial load onto First Nations staff - this means not putting the burden on individual staff members to explain what is and isn't culturally safe—it means taking responsibility for your own learning.

Understands the importance of language

- Not co-opting First Nations' preferred language if you're not First Nations
- De-colonising language; terms can be loaded; they can have historical meaning that not everyone knows or understands.
- Questions that are strength based and encourage self determination.

Trauma aware and practiced care – ways of knowing, being and doing

For Aboriginal and Torres Strait Islander peoples, the ongoing effects of trauma is something that continues to heavily affect their community. Suicide, intergenerational trauma, chronic diseases, deaths in custody, the Stolen Generations, child removal, racism, destruction to land, and many other impacts of colonisation can influence First Nations peoples' health and wellbeing.

Working with First Nations team members and consumer should involve all staff reaching an understanding of the impacts of colonial traumas. Their ways of working and the SEWB Framework can teach us a lot about working with impacted community members.

Understands the importance of having access to community but knowing that community can also be a source of pain due to intergenerational trauma and disconnection.

Acknowledging everyone's different journey.

Access to land and/ or being on country.

Having access to appropriate funding to meet the needs of First Nations consumers. This can include food, safe housing, employment, health care and basic needs.

Maintaining physical spaces that are calm, promote healing and have cultural elements (e.g. artwork, acknowledgments of Country).

Focusing on holistic and strength-based care.

FIRST NATIONS WAYS OF KNOWING, BEING & DOING

Understanding how grief and loss impacts wellbeing, and that Sorry Business can impact individuals and a whole community.

Understanding poverty and incarceration are not part of First Nations culture and are outcomes of colonisation.

Not rushing when someone is beginning their healing journey and always being guided by the consumer's choices. It also means acknowledging that an individual may be carrying trauma they are not ready to talk about, or do not want to talk about in a clinical environment.

Supporting someone on their journey through healing from trauma and not being bound to time frames set by services.

Education, professional and support needs

SEWB workers play a crucial role in providing support to consumers while managing their own social and emotional wellbeing as Aboriginal and Torres Strait Islander peoples.

They all bring their own lived experience of cultural connection into the sector. To enhance the effectiveness and sustainability of these roles, several strategies should be implemented and are noted below.

Racism and discrimination should not be tolerated in workplaces. Respectful engagement is key, and assumptions should not be made about a person's experience of cultural connection. Relevant policies and Reconciliation Actions Plans should be implemented whenever instances of racism and discrimination arise.

Developing staff succession planning is essential for retaining knowledge as experienced members leave. This includes creating clear pathways for career.

Providing access to paid cultural leave can further support SEWB workers in their roles and strengthen their connection to community.

EDUCATION, PROFESSIONAL AND SUPPORT NEEDS INCLUDE:

Cultural supervision and support are vital. This is something that workplaces need to take accountability for, implement and fund.

Establishing clear pathways for new staff into the workforce while recognising the diversity in cultural learning pathways.

First Nations workers should not be isolated or siloed in their roles and have access to self-care within work hours to promote their own SEWB.

Developing partnerships with Aboriginal community-controlled health organisations, other First Nation peak bodies and engagement with Elders and Leaders within the community.

Education for non-First Nations staff members is essential in the sector to effectively address the needs of First Nations consumers and staff alike. Comprehensive cultural competency training will address implicit biases among non-Indigenous workers and be a step in creating a more inclusive and supportive environment.

Diverse workforce perspectives

Introduction

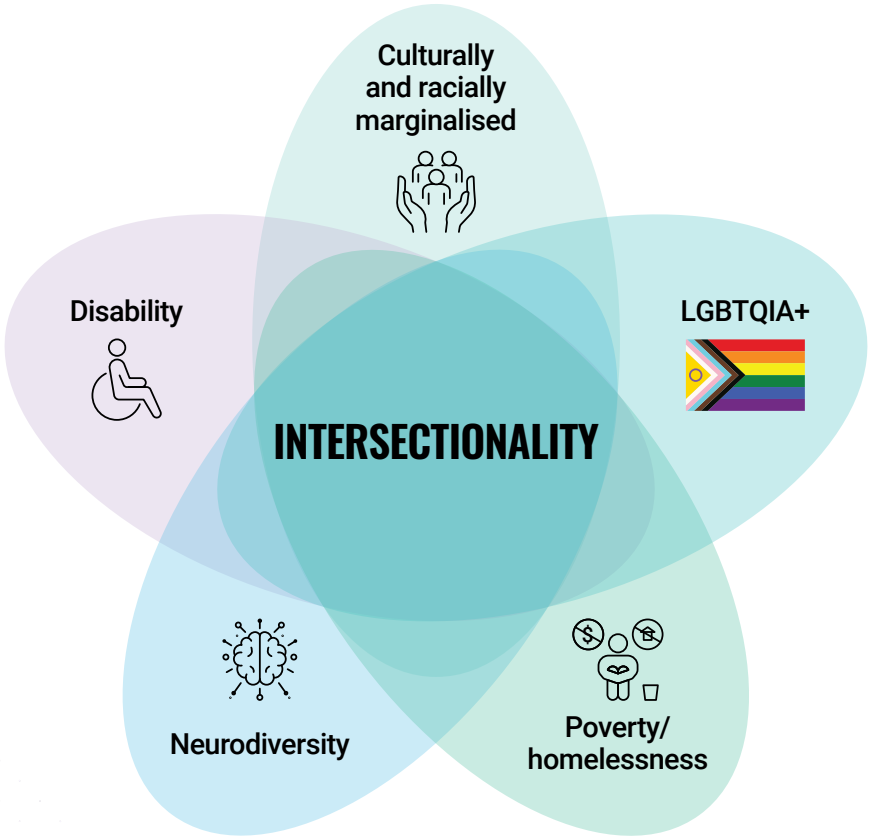
The consumer lived experience workforce in Victoria is diverse and reflects the diversity of Victoria's population. It should be acknowledged that marginalised identities can play a role in shaping a consumer's experiences. This includes both experiences of mental/emotional distress, as well as their experiences accessing mental health services, whereby the harms caused are compounded due to systemic racism and prejudice. As such, diversity within the consumer lived experience workforce and an understanding of intersectionality is important.

Marginalisation

It should be acknowledged that a consumer who holds a marginalised identity or multiple marginalised identities (e.g., someone with a disability who is also racially marginalised and has experienced houselessness) may experience the mental health system differently to those without these marginalised identities. It is also important to understand that an individual's identity as a mental health consumer is closely tied to their marginalised identities.

Intersectionality

Intersectionality is a way to understand discrimination against a person who holds multiple intersecting marginalised identities and receives unfavourable treatment based on this intersection. The term intersectionality is used differently to marginalisation because it refers to the specific instance when a person experiences discrimination arising from the intersection of multiple characteristics of marginalisation. Kimberlé Crenshaw has described intersectionality as "a metaphor for understanding the ways that multiple forms of inequality or disadvantage sometimes compound themselves and create obstacles that often are not understood among conventional ways of thinking."[76]



Diversity in practice

Consumer workers with diverse backgrounds and identities add strength to the workforce capability in centreing consumers' needs and preferences.

Some consumers may prefer accessing support from consumer workers with a shared cultural identity, while others would feel discomfort and prefer to work with someone outside of their community. This framework recommends against automatically 'matching' of consumers with workers merely based on shared identities or cultural background. Consumers' choice should always be explored through dialogue and their preferences should be honoured, instead of reverting to assumptions.

Consumer lived experience work plays a critical role in reducing shame and stigma for consumers accessing mental health services. This can be even more pronounced for consumers from culturally and racially marginalised identities where there may be additional layers of stigma associated with accessing mental health services, resulting in lower rates of service utilisation.

Embedding intersectional workforce perspectives in the consumer lived experience workforce is essential for workforce members to better understand the diverse communities they support.

My experiences of colonial harms have shaped and informed my ways of thinking, being and doing as a lived experience staff member. It's important for me to be around other people who understand where I'm coming from.

I've experienced houselessness. It upsets me when consumers I work with face similar things because I know there is no easy solution to housing insecurity with the system the way it currently is. It impacts me a lot and reminds me of how powerless I felt in the system.

I've experienced disparaging comments at work from other staff. It's hard to know if the discrimination is because of my cultural background, because I'm a woman, my lived experience, or all of these things.

I have a disability. The system didn't meet my needs when I was a consumer and now that I'm a worker, the same barriers are present. I don't want to be pushed out of the space because who can make positive change more than a person who is most impacted?

Co-production

Our sector is going through a transformation where adopting co-production methods is a high priority. The Royal Commission into Victoria's Mental Health System highlights the importance of utilising co-production to bring about positive system change. Additionally, a key message of the Victorian Department of Health's Mental Health Lived Experience Engagement Framework is that "consumers and carers will be placed at the centre of mental health policy and practice change by engaging them as partners in co-design and co-production."[77]

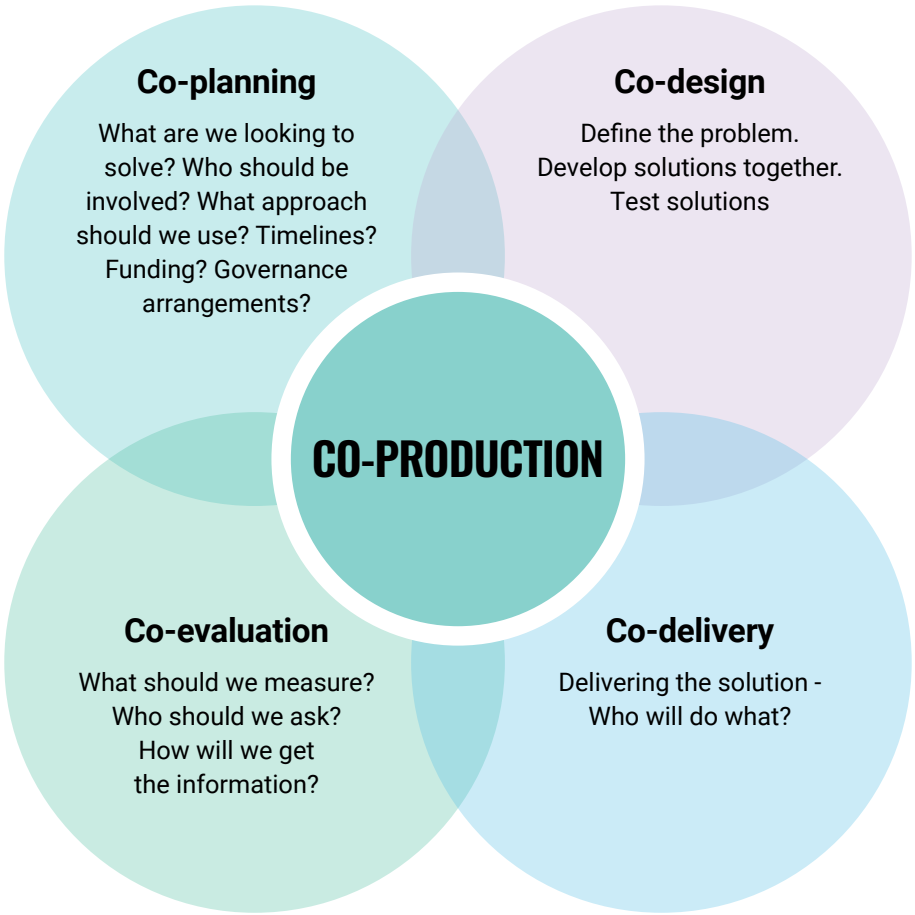
What is co-production?

Co-production is a collaborative way of working in which power and expertise is shared between people from different discipline backgrounds. In co-production, consumers are positioned as knowledge holders, leaders, and people from whom there is much to learn.

It differs from other forms of participation because it requires consumer leadership from the outset with consumers engaged in the initial thinking and priority-setting processes.

This diagram shows how co-production involves all stages of engaging in work from planning, to designing, delivering, and evaluating.

Consumers need to be involved in, or independently leading, decision-making around each question in the bubbles. Each phase (bubble) can stand alone as a collaborative activity, however unless all four phases engage with consumer leadership and perspective, the project or initiative cannot be called co-produced.[78]

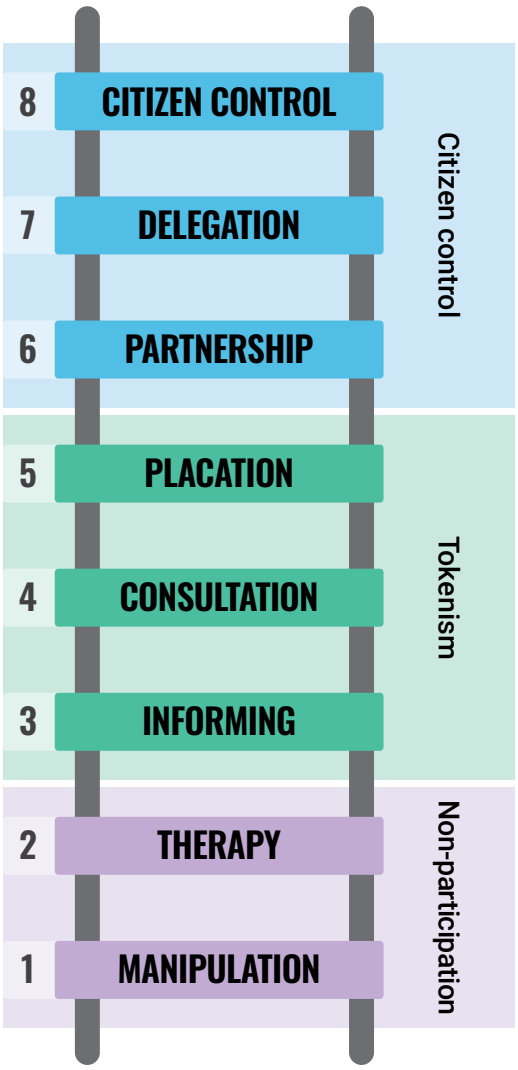


One essential element of all stages of co-production is acknowledging power differentials between the different disciplines/ perspectives (e.g., consumers and clinical staff).

A project does not have to be comprised of the same group members all the way through. For example, the governance group might stay the same, but consumers leading consultations, involved in the delivery or evaluation might be different across the different phases.

Arnstein's (1969) ladder of citizen participation is helpful to have in mind when deciding where a proposed project fits.[79]

While aiming for the highest level possible, being honest about where you are on the participation ladder is more important. 'Citizen control' equates to 'consumer-led' in our context. Delegation might mean that within a bigger program, consumers have delegated authority. 'Partnership' equates to co-production.



While aiming for the highest level possible, being honest about where you are is more important.

Practical considerations

Limitations such as budget, scope and timelines need to be shared up front from the outset.

If it looks like and feels like 'business as usual' then it's not co-production.

Taking risks is essential for innovation.

Deliberate co-production strategies focusing on bringing power to awareness should be embedded all the way through a project.

For example, mapping together where different power and privilege might sit, and returning to this frequently can be a way of keeping awareness.

Some projects are not suited to co-production. For example, for a project where a great number of different people's perspectives are sought, consultation may be the best approach. Having said that, there are still ways consultations can be done that elevate consumer knowledge and leadership, such as consumers developing consultation questions and facilitating groups, or developing surveys and analysing results.

Deliberate strategies for **addressing power imbalances** need to be enacted all the way through.

For example, consumers could have power of veto over decisions.

THEORIES AND KNOWLEDGE

This section builds on the key concepts (see Introduction) that have informed the development of theories and knowledge underpinning the consumer/survivor movement and by extension, the consumer workforce, over past decades.

Consumer/survivor knowledge is built on the movement's vision for justice and social change. As the needs of consumers and consumer workforce members changes over time, our theories and knowledge will develop to continue to meet the needs of people most impacted by mental health and wellbeing systems.

Our movement and workforce will continue to generate and advance our own collective knowledge and theories. Continuing to advance our own knowledge and theories is vital. Our knowledge is easily sidelined by the mental health system that doesn't understand our roles and our value.

Making our collective knowledge accessible to all consumer lived experience workers makes our unique theories and knowledge less vulnerable to being co-opted or dismissed by the wider sector.[80]

Training, learning and development

Training, learning, and development is essential for the consumer lived experience workforce as it equips people with the skills and knowledge necessary to effectively undertake their roles and further develop collective knowledge. The consumer discipline is a highly specialised field of work and involves navigating complex systems so that consumers and the consumer workforce are well supported.

The models described below enhance one's knowledge of consumer perspective work and have an underlying approach of valuing different ways people make meaning of their experiences. They are also founded on centreing the personal and social context of people's lives rather than being founded on a biomedical model; emotions are not pathologised or stigmatised. These approaches are consistent with the values and principles of consumer lived experience work.

Ongoing training, learning and development supports personal growth and the further development of lived expertise. By investing in the training, learning and development of the consumer lived experience workforce, we not only enhance individual skills and improve quality of support, but effectively drive systems change.

Formal training, learning and development is important; however, it should be noted that the primary requirement to enter the consumer lived experience workforce is an individual's lived experience as a consumer.

There is no single pathway for training, learning and development. There are many ways to deepen learning and knowledge of consumer perspective work, including the important skills that workers acquire from their peers in the workforce. The following models of training appear alphabetically.

Alternatives to Suicide

What is it?

The Alternatives to Suicide (Alt2Su) approach was developed by The Wildflower Alliance (formerly the Western Massachusetts Recovery Learning Community) in the US. Alt2Su is a peer-to-peer support practice for voicing, sitting with, understanding, and moving through suicidal thoughts. Key to the approach is a responsibility to be honest, transparent, and present with one another, and knowing we cannot be responsible for one another's choices or actions.

Key principles

Facilitators openly identify with the experience of suicidal thoughts. There is no 'red tape' to attend a group, other than the desire for mutual support. Privacy is maintained at all times and no documentation is kept. Each person is honoured as the expert of their own experiences and the group is built on mutual connection, relationships and an understanding that everyone makes meaning in their own unique way. A principle of non-coercion means the group becomes a place where it is completely safe to talk about suicide without fear of repercussions. The approach can lead to identifying underlying causes of distress for the individual and reducing shame and isolation.

Emotional CPR

What is it?

Emotional CPR (eCPR) is an educational program designed to teach people to assist others through an emotional crisis. It has a focus on connection, empowerment and relationships.

Key principles

The 'connecting' process of eCPR involves deepening listening skills, 'being with', and creating a sense of safety for the person experiencing a crisis. The 'empowering' process helps people better understand how to feel empowered themselves as well as to assist others to feel more hopeful and engaged in life. In the 'revitalisating' process, people re-engage in relationships with their support system and engage in routines that reinforces the person's sense of mastery and accomplishment.

Hearing voices approach

What is it?

The hearing voices approach is the peer-led recovery model for people who hear voices, see and sense things around them that others do not. The Hearing Voices Movement was established in 1987 by Romme and Escher, both from the Netherlands, with the formation of Stichting Weerklank (Foundation Resonance), a peer led support organisation for people who hear voices. In 1988, the Hearing Voices Network was established in England with the active support of Romme.

Key principles

Principles informing the hearing voices approach include that hearing voices is not in itself a sign of 'mental illness' but rather, part of the diversity of being human and common in that 3-10 per cent of the population will hear a voice or voices in their lifetime. Hearing voices is often related to challenges in life history. If hearing voices causes distress, the person who hears the voices can learn strategies to cope with the experience often by confronting the past problems that lie behind the experience. Techniques can involve 'dialoguing' with the voices, or being interviewed about them, such as finding out how many there are, when they started, and what they say.

Intentional Peer Support

What is it?

Intentional Peer Support (IPS) is a peer support practice about creating purposeful relationships that are built on mutual growth and development.[81] In the training, people are encouraged to explore life patterns, look at things from different lenses and challenge each other. The training is suitable across all consumer workforce roles and is the main training for the Victorian consumer workforce. IPS comprises five days of core training. There is also an advanced course and a train-the-trainer course. Beyond the transformation of relationships, IPS seeks to transform communities and society.

Key principles

Shery Mead, an American consumer/survivor, developed the practice. The training is based on four principles: connection, world view, mutuality and moving towards. These principles are applied in relationship building. There are also three tasks: from helping to learning together, from individual to relationship and from fear to hope and possibility.

In the IPS approach, putting the connection of the relationship first is transformative. Understanding people's world views supports connection, and transparent communication, including naming disconnection, allows for conversation to be mutual. Other possibilities emerge when authentic listening is prioritised and the relationship is empowered, trust is elevated and a conversation occurs, moving towards a future of curious relationship development. Mead radically reframes the idea of 'helping' to 'learning together'. In this sense, one person is not in need of help while the other person provides the help, but rather, both people in the relationship are learning about themselves, each other and the relationship. In IPS, people are encouraged to express their own needs in an open way, and respect the needs of others, rather than for example, talk about 'boundaries'.

Open Dialogue

What is it?

Open Dialogue emerged from Finland in the 1980s. It's a therapeutic approach that works with the family and social network of a person who is seeking to better understand their distress. Two facilitators meet with the person and their network in a reflective space that allows all voices to be heard. Distress does not exist in isolation, within an individual, it exists within a social context. Through the process of working within this social context new meanings and understandings are identified.

Key principles

Key principles of Open Dialogue include that help is immediate, beginning with a treatment meeting within 24 hours of contact with a team. Open Dialogue takes a social perspective that includes the gathering of clinicians, family members, friends, co-workers and other relevant persons for a joint discussion. The approach embraces uncertainty by encouraging open conversation and avoiding premature conclusions This creates a dialogue in which each person's voice is present. Instead of having treatment meetings without the person present, all meetings are held with the family/network, resulting in a sense of 'with-ness' rather than 'about-ness'. People with lived experience have been trained to provide open dialogue in roles working alongside therapists for example in the United Kingdom, US and Australia.

Victorian-developed trainings

Athena Consumer Workforce Consulting training

Athena Consumer Workforce Consulting is an experienced consumer/survivor training and consultancy partnership committed to supporting the growth of consumer perspective leadership across the Victorian mental health sector and community. Athena provides training for new and established consumer workers across all consumer workforce roles in the mental health and wellbeing system through to leadership and governance.

https://www.athenacwc.com.au/courses

Centre for Mental Health Learning training website

Training advertised on the CMHL website is available for lived experience workforces working in either public clinical or community mental health and wellbeing state-funded roles. Registration for training is required, which is currently provided online. The training calendar is available here:

https://cmhl.org.au/cmhl-amhs-calendar

Certificate IV in Mental Health Peer Work (offered through the Victorian TAFE sector)

This course is designed for people who want to use their lived experience with mental health to assist others by learning skills that promote wellbeing. This course is often taught by facilitators with lived experience. Skills include theoretical training, communication skills, coaching skills, and listening skills. Undertaking this training involves a placement where learning can be put into practice. Further information can be found here:

https://www.mhvic.org.au/index.php?option=com_content&view=article&id=195:certificate-iv-mental-health-peer-work&catid=39:training&Itemid=452

Ongoing training, learning and development supports personal growth and the further development of lived expertise.

Consumer Perspective Supervision training (offered through Inside Out & Associates Australia)

This training aims to build discipline-specific CPS capability and capacity in Victoria in order to provide CPS to the consumer/peer workforce. It is not designed to be provided to the non-peer workforce, such as clinicians and non-peer line managers.

The CPS course is written and delivered by the consumer lived experience workforce, including leaders, supervisors and educators. The training involves workshops as well as small group co-reflection sessions to facilitate co-learning support for training participants, provided by people with extensive experience in mental health consumer lived experience work. Further information can be found here:

https://insideoutconversations.com.au/consumer-perspective-supervision-courses/

Human Rights Training – Simon Katterl Consulting

This training can be undertaken in person or online. The course content covers what human rights are and why they matter; what human rights mean for governance; embedding human rights; and change management and culture. The training is suitable for organisations seeking to embed human rights throughout, and for consumer workers, particularly those engaged in change management and service leadership.

https://www.simonkatterlconsulting.com/human-rights-training-1

NOTES AND REFERENCES

1. Guze, S. B. (1992) Why psychiatry is a medical specialty. Oxford University Press.
2. Huda, A. S. (2020). The medical model and its application in mental health. International Review of Psychiatry, 33(5), 463–470. https://doi.org/10.1080/09540261.2020.1845125
3. Diversity Council Australia. (2023) Words at work: Should we use CALD or CARM?. Available at https://www.dca.org.au/news/blog/words-at-work-should-we-use-cald-or-carm. (Accessed 11th October 2024).
4. Roper, C., Grey, F. and Cadogan, E. (2018) Co-production - Putting principles into practice in mental health contexts. Available at: https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf (Accessed 20 June 2024).
5. Nazim, M., & Mukherjee, B. (2016) Knowledge management in libraries: Concepts, tools and approaches. Chandos publishing.
6. Victorian Mental Illness Awareness Council (VMIAC) and Centre for Psychiatric Nursing (2018) Consumer Perspective Supervision A framework for supporting the consumer workforce. University of Melbourne. Available at: https://cmhl.org.au/sites/default/files/resources-pdfs/FINAL%20CPS%20framework%2018.pdf
7. VMIAC (2024) About Mental Health Consumers. Available at https://www.vmiac.org.au/about-consumers/ (Accessed 23 October 2024)
8. Victorian Mental Illness Awareness Council (VMIAC) and Centre for Psychiatric Nursing (2018) Consumer Perspective Supervision A framework for supporting the consumer workforce. University of Melbourne. Available at: https://cmhl.org.au/sites/default/files/resources-pdfs/FINAL%20CPS%20framework%2018.pdf
9. Our Consumer Place, (n.d.) What do we mean by consumer perspective? Our Consumer Place. http://www.ourconsumerplace.com.au/consumer/helpsheet?id=4755
10. Byrne, L., & Wykes, T. (2020) A role for lived experience mental health leadership in the age of Covid-19. Journal of Mental Health, 29(3), 243–246. https://doi.org/10.1080/09638237.2020.1766002
11. Bluebird, G (n.d.) History of the Consumer/Survivor Movement. Available on: History of the Consumer Movement.1docx. (Accessed on 23rd October 2024).
12. Epstein, M (2013) THE CONSUMER MOVEMENT in AUSTRALIA a Memoir of an Old Campaigner. Available on Microsoft Word - History of Consumer Movement.doc. (Accessed 23 October 2024).
13. VMIAC (2019) The Consumer Movement. Available on The consumer movement – VMIAC. (Accessed 23 October 2024).
14. Bluebird, G (n.d.) History of the Consumer/Survivor Movement. Available on: History of the Consumer Movement.1docx. (Accessed on 23rd October 2024).

15. Epstein, M (2013) THE CONSUMER MOVEMENT in AUSTRALIA a Memoir of an Old Campaigner. Available on Microsoft Word - History of Consumer Movement.doc. (Accessed 23 October 2024).
16. VMIAC (2019) The Consumer Movement. Available on The consumer movement – VMIAC. (Accessed 23 October 2024).
17. Roper, C., Grey, F. and Cadogan, E. (2018) Co-production - Putting principles into practice in mental health contexts. Available at: https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf (Accessed 20 June 2024).
18. Ibid.
19. Penny, D., & Prescott, L., (2016) 'The Co-optation of survivor knowledge: the Danger of Substituted Value and Voice', in J. Russo & A Sweeney. (Eds.), Searching for a Rose Garden, Challenging Psychiatry, Fostering Mad Studies (pp.35-45) PCCS Books.
20. Ibid.
21. Hammarfelt, B. (2019) Discipline. ISKO encyclopedia of knowledge organization.
22. Victorian Mental Illness Awareness Council (VMIAC) and Centre for Psychiatric Nursing (2018) Consumer Perspective Supervision A framework for supporting the consumer workforce. University of Melbourne. Available at: https://cmhl.org.au/sites/default/files/resources-pdfs/FINAL%20CPS%20framework%2018.pdf
23. AHURI (n.d.) Indigenous perspectives. Available at https://www.ahuri.edu.au/research/cities/indigenous-perspectives (Accessed 18th October 2024).
24. Auger, P. (2017). Information sources in grey literature. Walter de Gruyter GmbH & co KG.
25. Uq.edu.au (2024) "Library Guides: Grey Literature: Introduction." Available on: guides library.uq.edu.au/how-to-find/grey-literature. (Accessed 21 October 2024).
26. White, G., Weldon, P., Galatis, H., Thomas, J., Lawrence, A., Tyndall, J (2013) Grey literature in Australian education. Swinburne. Journal contribution. https://doi.org/10.25916/sut.26244053.v1
27. Crenshaw, K. (2005) Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color (1994). In R. K. Bergen, J. L. Edleson, & C. M. Renzetti, Violence against women: Classic papers (pp. 282–313). Pearson Education New Zealand.
28. Collins, P. H., & Bilge, S. (2020) Intersectionality. John Wiley & Sons.
29. Weldon, S. L. (2008) Intersectionality. Politics, gender, and concepts: Theory and methodology, 193-218.
30. Roennfeldt H, Byrne L. (n.d.) Skin in the game: The professionalization of lived experience roles in mental health. Int J Ment Health Nurs. 2021 Oct;30 Suppl 1:1445-1455. doi: 10.1111/inm.12898. Epub 2021 Jun 17. PMID: 34137149.

31. Snyder, H. (2019) Literature review as a research methodology: An overview and guidelines. Journal of business research, 104, 333-339.
32. Department of Health. Victoria, A. (2024) Workforce initiatives: Lived and living experience workforces (llews), Department of Health. Victoria, Australia. Available at: https://www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives (Accessed: 20 June 2024).
33. Our Consumer Place, (n.d.) What do we mean by consumer perspective? Our Consumer Place. http://www.ourconsumerplace.com.au/consumer/helpsheet?id=4755

    Our Consumer Place, (n.d.) Consumer Support Structures. Our Consumer Place. https://www.ourcommunity.com.au/files/OCP/Section%20One.pdf
34. Mowat, J. G. (2015) Towards a new conceptualisation of marginalisation. European Educational Research Journal, 14(5), 454-476. https://doi.org/10.1177/1474904115589864
35. Wimmer, C. (2024) Exclusions and Marginalisation, in Jodhka, S.S., Rehbein, B. (eds) Global Handbook of Inequality. Springer, Cham. https://doi.org/10.1007/978-3-030-97417-6_118-1
36. Victorian Mental Illness Awareness Council (VMIAC) and Centre for Psychiatric Nursing (2018) Consumer Perspective Supervision A framework for supporting the consumer workforce. University of Melbourne. Available at: https://cmhl.org.au/sites/default/files/resources-pdfs/FINAL%20CPS%20framework%2018.pdf
37. Houseworth, L. (2021). How the Black Panthers Revolutionized Self-Care. Teen Vogue. Available at: The Radical History of Self-Care | Teen Vogue. (Accessed 18th October 2024).
38. Ahmed, S (2014) 'Self-Care as Warfare'. Available at: https://feministkilljoys.com/2014/08/25/selfcare-as-warfare/ (accessed 7 August 2019).
39. Gee, G., Dudgeon, P., Schultz, C., Hart, A. & Kelly, K. (2014) Aboriginal and Torres Strait Islander social and emotional wellbeing. Available at: https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/wt-part-1-chapt-4-final.pdf
40. Australian Human Rights Commission (2003) Social Justice and human rights for Aboriginal and Torres Strait Islander People. Available at: https://humanrights.gov.au/sites/default/files/content/social_justice/infosheet/infosheet_sj.pdf. (Accessed 18th October 2024).
41. Victorian Mental Illness Awareness Council (VMIAC) and Centre for Psychiatric Nursing (2018) Consumer Perspective Supervision A framework for supporting the consumer workforce. University of Melbourne. Available at: https://cmhl.org.au/sites/default/files/resources-pdfs/FINAL%20CPS%20framework%2018.pdf
42. Department of Health. Victoria (2023) Mental Health Workforce Strategy and our workforce, our future, Mental health workforce strategy. Available at: https://www.health.vic.gov.au/publications/mental-health-workforce-strategy (Accessed 20 June 2024).

43. Atkinson, P., Baird, M., & Adams, K. (2021) Are you really using Yarning research? Mapping Social and Family Yarning to strengthen Yarning research quality. AlterNative: An International Journal of Indigenous Peoples, 17(2), 191-201. https://doi.org/10.1177/11771801211015442
44. Sinclair, A., Fernandes, C., Gillieatt, S., & Mahboub, L. (2023) Peer work in Australian mental health policy: What 'problems' are we solving and to what effect(s)? Disability & Society, 39(7), 1656–1681. https://doi.org/10.1080/09687599.2022.2160926
45. Madness News Network (2024) https://madnessnetworknews.com/ (Accessed 25 October 2024).
46. Mead, S., Hilton, D., & Curtis, L. (2001) Peer support: A theoretical perspective. Psychiatric Rehabilitation Journal, 25(2), 134–141. https://doi.org/10.1037/h0095032
47. Penny, D., & Prescott, L., (2016) 'The Co-optation of survivor knowledge: the Danger of Substituted Value and Voice', in J. Russo & A Sweeney. (Eds.), Searching for a Rose Garden, Challenging Psychiatry, Fostering Mad Studies (pp.35-45) PCCS Books.
48. Roses in the Ocean (2024) https://rosesintheocean.com.au/lived-experience-of-suicide/what-is-lived-experience/ (Accessed 25 October 2024).
49. Russo J (2023) Psychiatrization, assertions of epistemic justice, and the question of agency. Front. Sociol. 8:1092298.doi: 10.3389/fsoc.2023.1092298.
50. Penny, D., & Prescott, L., (2016) 'The Co-optation of survivor knowledge: the Danger of Substituted Value and Voice', in J. Russo & A Sweeney. (Eds.), Searching for a Rose Garden, Challenging Psychiatry, Fostering Mad Studies (pp.35-45) PCCS Books.
51. Sinclair, A., Fernandes, C., Gillieatt, S., & Mahboub, L. (2023) Peer work in Australian mental health policy: What 'problems' are we solving and to what effect(s)? Disability & Society, 39(7), 1656–1681. https://doi.org/10.1080/09687599.2022.2160926
52. Fricker, M., (2007). Epistemic Injustice: Power and the Ethics of Knowing, Oxford University Press.
53. Roper, C. (2019). Ethical Peril, Violence, and "Dirty Hands": Ethical Consequences of Mental Health Laws. Journal of Ethics in Mental Health, 1–17.
54. Daya, I. (2022). Russian dolls and epistemic crypts: A lived experience reflection on epistemic injustice and psychiatric confinement. Incarceration, 3(2). https://doi.org/10.1177/26326663221103445
55. Liegghio, M. (2013) Chapter 5: A denial of being: Psychiatrization as epistemic violence. In B. LeFrancois, R. Menzies, & G. Reaume (Ed.s.), Mad matters: A critical Canadian reader. (p.p. 122-129). Toronto, Ontario: Canadian Scholars' Press.
56. Webb, D., (2010) Thinking About Suicide: Contemplating and Comprehending the Urge to Die, PCCS Books, United Kingdom, Manchester
57. Byrne, L., & Wykes, T. (2020) A role for lived experience mental health leadership in the age of Covid-19. Journal of Mental Health, 29(3), 243–246. https://doi.org/10.1080/09638237.2020.1766002
58. Roennfeldt H, Byrne L. (n.d.) Skin in the game: The professionalization of lived experience roles in mental health. Int J Ment Health Nurs. 2021 Oct;30 Suppl 1:1445-1455. doi: 10.1111/inm.12898. Epub 2021 Jun 17. PMID: 34137149.

59. Sinclair, A., Fernandes, C., Gillieatt, S., & Mahboub, L. (2023) Peer work in Australian mental health policy: What 'problems' are we solving and to what effect(s)? Disability & Society, 39(7), 1656–1681. https://doi.org/10.1080/09687599.2022.2160926
60. Penny, D., & Prescott, L., (2016) 'The Co-optation of survivor knowledge: the Danger of Substituted Value and Voice', in J. Russo & A Sweeney. (Eds.), Searching for a Rose Garden, Challenging Psychiatry, Fostering Mad Studies (pp.35-45) PCCS Books.
61. Liegghio, M. (2013) Chapter 5: A denial of being: Psychiatrization as epistemic violence. In B. LeFrancois, R. Menzies, & G. Reaume (Ed.s.), Mad matters: A critical Canadian reader. (p.p. 122-129). Toronto, Ontario: Canadian Scholars' Press.
62. Beresford, P. (2019) 'Mad', Mad studies and advancing inclusive resistance. Disability & Society, 35(8), 1337–1342. https://doi.org/10.1080/09687599.2019.1692168
63. Stewart, S., Scholz, B., Gordon, S. and Happell, B. (2019) 'It depends what you mean by leadership': An analysis of stakeholder perspectives on consumer leadership. Int J Mental Health Nurse, 28: 339-350. https://doi.org/10.1111/inm.12542
64. Penny, D., & Prescott, L., (2016) 'The Co-optation of survivor knowledge: the Danger of Substituted Value and Voice', in J. Russo & A Sweeney. (Eds.), Searching for a Rose Garden, Challenging Psychiatry, Fostering Mad Studies (pp.35-45) PCCS Books.
65. Sinclair, A., Fernandes, C., Gillieatt, S., & Mahboub, L. (2023) Peer work in Australian mental health policy: What 'problems' are we solving and to what effect(s)? Disability & Society, 39(7), 1656–1681. https://doi.org/10.1080/09687599.2022.2160926
66. Mills, C., (2015) 'The Global Politics of Disablement: Assuming Impairment and Erasing Complexity'. In H. Spandler & J. Anderson & B. Sapey. (Eds.), The Politics of Disablement (pp.199-213). Policy Press.
67. Plumb, A., (2015) 'The Convention on the Rights of Persons with Disabilities: Out of the Frying Pan into the Fire? Mental Health Service Users and survivors aligning with the Disability Movement', in H. Spandler & J. Anderson & B. Sapey. (Eds.), The Politics of Disablement (pp.183-198). Policy Press.
68. Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., & Saunders, M. (2021). *National lived experience workforce guidelines*. National Mental Health Commission
69. Roennfeldt, H., Chapman, M., & Byrne, L. (2024). *What makes consumer lived experience work unique* [Unpublished report]. RMIT University.
70. Mental Health Commission. (2022). *The Western Australia Lived experience (peer) workforce framework*. https://livedexperienceworkforces.com.au/wp-content/uploads/2022/10/mhc-lived_experience-pw-framework-oct2022-digital.pdf
71. Queensland Health. (2021). *Peer workforce support framework*. https://www.health.qld.gov.au/__data/assets/pdf_file/0039/929667/peer-workforce-support-framework.pdf
72. Bennetts, W., Pinches, A., Paluch, T., & Fossey, E. (2013) Real lives, real jobs: Sustaining consumer perspective work in the mental health sector. Advances in Mental Health, 11(3), 313–326. https://doi.org/10.5172/jamh.2013.11.3.313

73. Victorian Mental Illness Awareness Council (VMIAC) and Centre for Psychiatric Nursing (2018) Consumer Perspective Supervision A framework for supporting the consumer workforce. University of Melbourne. Available at: https://cmhl.org.au/sites/default/files/resources-pdfs/FINAL%20CPS%20framework%2018.pdf

74. Gee, G., Dudgeon, P., Schultz, C., Hart, A. & Kelly, K. (2014) Aboriginal and Torres Strait Islander social and emotional wellbeing. Available at: https://www.telethonkids.org.au/globalassets/media/documents/aboriginal-health/working-together-second-edition/wt-part-1-chapt-4-final.pdf

75. United Nations (2007) UN Declaration on the Rights of Indigenous Peoples, OHCHR, United Nations, accessed 18 October 2024. Available at UN Declaration on the Rights of Indigenous Peoples | OHCHR

76. Crenshaw, K. (2005) Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color (1994). In R. K. Bergen, J. L. Edleson, & C. M. Renzetti, Violence against women: Classic papers (pp. 282–313). Pearson Education New Zealand.

77. Department of Health and Human Services. (2017) Lived experience workforce positions in Victorian public mental health services. Retrieved from www2.health.vic.gov.au/mental-health/workforce-andtraining/lived-experience-workforce.

78. Roper, C., Grey, F. and Cadogan, E. (2018) Co-production - Putting principles into practice in mental health contexts. Available at: https://healthsciences.unimelb.edu.au/__data/assets/pdf_file/0007/3392215/Coproduction_putting-principles-into-practice.pdf (Accessed 20 June 2024).

79. Arnstein, S. (1969), "A Ladder of Citizen Participation," Journal of the American Institute of Planners, 35(4), 216–224

80. Penny, D., & Prescott, L., (2016) 'The Co-optation of survivor knowledge: the Danger of Substituted Value and Voice', in J. Russo & A Sweeney. (Eds.), Searching for a Rose Garden, Challenging Psychiatry, Fostering Mad Studies (pp.35-45) PCCS Books.

81. Mead, S. (2014) Intentional Peer Support: An alternative approach. Vermont USA.

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