Lived and Living Experience: Leadership, Workforce and Partnerships

Analysis of the Royal Commission into Victoria's Mental Health System

Authored by

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Acknowledgement of Country

The authors acknowledge this project has been carried out on Aboriginal Country throughout Victoria and we acknowledge the traditional custodians of the land, respecting their continuing connections to land, sea, and community.

We pay our respects to their Elders, both past, present and emerging.

This project relates to mental health and addictions, and we particularly acknowledge the lived and living experiences of Aboriginal and Torres Strait Islander peoples in their personal and collective journeys. This includes the inequitable treatment that Aboriginal and Torres Strait Islanders have received, and continue to receive, by health and related services and a valuing of their perspectives on social and emotional wellbeing.

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Executive summary

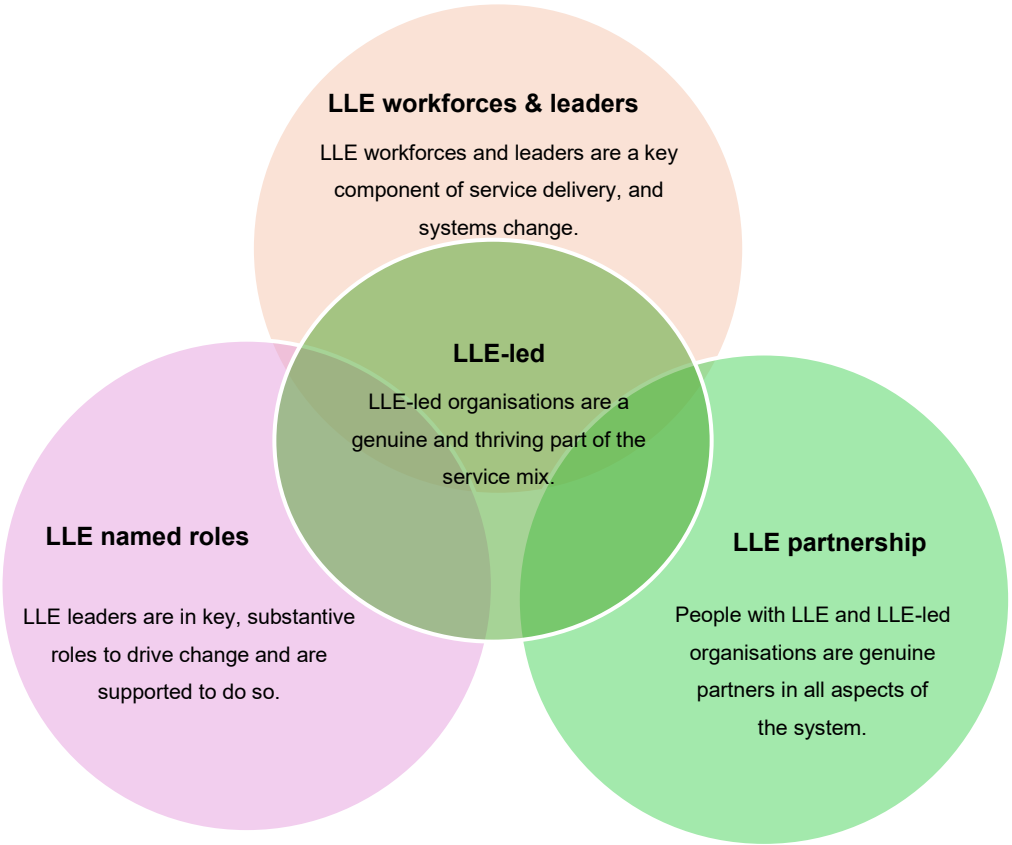
This is an analysis of leadership, partnership and workforce for lived and living experience (LLE) in the Royal Commission into Victoria's Mental Health System (RCVMHS), carried out by SJ Haywood and Gareth Edwards in partnership with SHARC and the Department of Health (DH) to support development of the LLE Leadership Framework.

The brief was to explore narrative and directions on LLE leadership, partnership and workforce in the RCVMHS, identifying the recommendations and gaps.

The main finding is that the recommendations in the RCVMHS have a clear narrative and vision for LLE leadership, workforce and partnership, as well as LLE-led organisations and initiatives. Notably "a central role for people with lived experience[1]… in the ongoing design and development of the system, and in the delivery of services"[2].

A vision for this was derived from the analysis covering four interrelated areas: LLE-led organisations, LLE named roles, LLE workforce and leaders, and LLE Partnership.

The recommendations, narrative and directions are presented in each of these four areas.



[1] The RCVMHS used the phrase 'lived experience' which has been updated in this report to 'lived and living experience' to align with current use in the sector.

[2] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Vol. 3, Introduction, p3.

Alongside formal recommendations - e.g. Recommendation 29 for a Consumer Agency, 31 for Carer-led Centres and Interim Recommendation 5 for a Healing Place - the analysis also captures important nuances that could be easy to miss as ‘soft recommendations’ in the RCVMHS’s assertive commentary. For example, Recommendation 8 (“response to crisis”) calls for support from a “non-clinical worker such as a peer worker”. A small line in a substantial recommendation but one with deep implications for the LLE driven reform. There are many examples such as this throughout the recommendations, that have significant impact on the scope and vision for LLE-led organisations, as well as LLE leadership, partnership and workforces.

This analysis also includes consideration of gaps in the RCVMHS through the four areas, with overarching gaps being definitions of leadership, workforce and partnership, the exclusion of the Alcohol and Drug Sector and guidance on implementing ‘soft recommendations.’

A significant risk was also identified that interpreting and implementing the recommendations could fall short of the RCVMHS vision for LLE-led services and organisations are a genuine part of a diverse service mix and diminishes the intent that these are a “prominent feature” of a diverse service mix.

The report concludes with advice and next steps relating to the development of the LLE Leadership Strategy (i.e. address the narrative, directions and gaps) along with ideas to strengthen LLE-led organisations and services along with Regional Boards and ideas to map and monitor the RCVMHS recommendations as they are implemented.

High-level Royal Commission narrative and directions

The recommendations in the Royal Commission have a clear narrative and vision for LLE leadership, workforce and partnership, as well as LLE-led organisations and initiatives. As the final report states, the Royal Commission recommends.

> "a central role for people with lived experience… in the ongoing design and development of the system, and in the delivery of services"[3].

Improving the mental health, addiction and wellbeing outcomes and service experiences for all Victorians depends on people with lived and living experience:

1. Leading system reform and the sector
2. Leading and working in the sector
3. Partnering with the sector
4. Running their own organisations and services

The diagram below is a vision for LLE leadership, workforce and partnership followed by details on each of the four areas. This analysis combines LLE workforce and leaders as they are functionally inseparable and has differentiated key LLE named roles and LLE-Led organisations/services as significant change catalysts and drivers.

Figure 1 Vision for LLE leadership, workforce and partnership

[3] State of Victoria, Royal Commission into Victoria's Mental Health System, Final Report, Vol. 3, Introduction, p3.

LLE-led organisations

LLE-led organisations are a genuine part of the service offering.

Recommendations that are LLE-led and delivered, or with LLE in key leadership roles, and will drive world-first structural change for LLE leadership, workforce and organisations.

Recommendations

Int. Rec 1	**Victorian Collaborative Centre (VCC)** A. Lived experience (Consumer and Family/Carer) on Board B. Co-Director with Lived Experience (LE) (Consumer) C. Drive exemplary practice for full and effective participation of people with LE across the mental health (MH) system
Int. Rec 5	**Healing Place: LE-designed and delivered residential service** A. Delivered and managed by majority LE workforce B. Facilitated through partnership with community health service and/or area mental health service (AMHS) C. Co-produced with LE and provides short-term treatment, care and support D. Evaluation to guide the expansion of similar services
Rec 9	**Safe spaces and crisis respite** A. Develop diverse and innovative consumer-led services for suicidal crisis, where appropriate in partnership with NGOs B. In collaboration with the Consumer Agency (Rec 29) and NGOs, establish one drop-in/crisis respite per region (8 total) and 4x across state co-designed with young people
Rec 23	**Trauma support within VCC's Statewide Trauma Service** A. Digital peer-led support platform for consumers with lived experience of trauma to access peer support networks
Rec 29	**Consumer Agency** A. Chaired by Consumer, Board with majority LE (Consumer), majority of positions are LE B. Deliver training to support development of peer-led organisations C. Develop and deliver LE-led mental health and wellbeing (MH&W) services D. Facilitate co-location, shared resourcing, learning, partnerships and networks between LE-leaders and LE-led organisations
Rec 31	**Carer-led centres in each region (8 total)** A. Provide tailored information and connecting Family/Carer with supports B. Provide funds for immediate practical needs (e.g. short term respite) C. Deliver Family/Carer peer support groups
Rec 31	**Statewide Family/Carer peer call-back service for suicidal behaviour** A. Family/Carer warmline to provide peer support for family/carers with a consumer experiencing suicidal ideation and behaviour

Rec 48	**Supporting new and existing service providers** A. Service provider standards at full-maturity call for LLE to be partners and leaders

Assertive commentary or soft recommendations:	
Rec 5	**Peer support, education and self-help in Community Model** Every Local/AMH&W service should provide services with peer support throughout, including: A. Education, including Recovery Colleges at each AMH&S B. Peer support C. Self-help
Rec 11	**New models of care for bed-based services** A. Recommends investing in a "wide range of time-limited and flexible residential respite services" including Healing Place (Rec 5)
Rec 64	**Consumer-led innovation** A. A new mental health and wellbeing innovation fund that must fund consumer-led initiatives

Narrative and directions

The diagram below outlines the key narrative and directions from the above recommendations, with each considered in detail:

LLE-led services should be a genuine option amongst a diverse mix of service providers.

LLE-led organisations are key collaborators and drivers of change.

Key agencies should support LLE-led organisations to emerge.

LLE-led solutions for specific experiences and populations.

LLE-led services should be a genuine option amongst a diverse mix of service providers.

- LLE-led services should be a genuine option amongst a diverse mix of service providers, with access statewide, with the intention that LLE services be a network of thriving and supported services providers.

- As the Interim Report attests, “services led, designed and delivered by people with lived experience should feature prominently”[4]. The Commission saw peer-led services as a way to “incorporate lived experience into all aspects of the mental health system, including service delivery.”[5]

- For this to happen there needs to be substantial investment in creating the conditions (e.g. Consumer Agency) for these services to emerge, including “supporting new providers, such as those that are consumer-led, and encouraging provider partnerships that bring together providers with complementary strengths so they can offer innovative services.”[6]

- Alongside this, the Commission mandated Family/Carer-led services statewide (Carer-led centres), recognising the need and benefit of Family/Carer-led supports.

- Where demonstration sites or pilot LLE-led services have been recommended, it is expected that these are evaluated and expanded. For example, for Int. Rec 5 (Healing Place), it is expected these services would be expanded, with recurrent funding to “ensure the service endures.”[7]

- Where there are LLE delivered services, it is expected some of these will be provided by LLE-led organisations, i.e. it is expected that the service standards will bring about new LLE-led organisations as part of the service mix. For example, services in the new community model being provided by LLE-led organisations.

- Service provider standards (Rec 48) are designed to incentivise LLE-led organisations to be able to become genuine options amongst a diverse service mix, as discussed below.

DH, Regional Boards, Service Standards and the Consumer Agency will play a key role in supporting LLE-led organisations to emerge.

- “Department of Health and Regional Boards will support providers, including services led by people with lived experience of mental illness or psychological distress, to thrive and develop over time as part of a diverse service offering. This endeavour will also be supported by a new set of service standards, with tools, resources and supports to develop the capabilities of providers, including providers led by people with lived experience of mental illness or psychological distress.”[8]

- It was seen that Regional Boards would play a proactive role in supporting services to meet the service standards; “Regional Boards may invest in tailored supports for providers still in development so they can progress towards the minimum standards.”[9]

- The Consumer Agency will play a key role; “a new agency led by [consumers]... will help establish organisations, including services led by people with lived experience of mental illness or psychological distress. These organisations will be supported to develop over time through accredited training and resources.”[10]

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[4] State of Victoria, Royal Commission into Victoria’s Mental Health System, Interim Report, Part 5, p492.

[5] Interim Report, Part 5, p492.

[6] Final Report, Vol 4, Ch 28, p127.

[7] Interim Report, Part 5, p500.

[8] Final Report Vol 3, Ch 18, p29.

[9] Final Report Vol 4, Ch 28, p131.

[10] Final Report Vol 3, Introduction, p4.

- Given the interdependency of the Consumer Agency on other partnerships and the commissioning of services, the Commission recommended the Consumer Agency be established as a matter of priority, with the board operating and agency functions (service delivery, training, etc) initiated by end of 2022.[11]

LLE-led organisations are key collaborators and drivers of change.

- LLE-led organisations are key drivers of change and will be key collaborators in systems change.
- Key organisations - Victorian Collaborative Centre, MH&W Commission, Lived Experience Branch are mandated to have key LLE positions in substantive positions and be exemplars of full and effective participation of LLE.
- For consumer-led services, the Consumer Agency (Rec 29) is a key collaborator and incubator, with a number of co-dependent recommendations in which it is designed to play a key role, e.g. building on the LLE-led service (Int. Rec 5)
- The lack of LLE-led organisations and services, in particular the lack of any peer-led alternatives to hospital care "reflect broader structural failings of the mental health system"[12] identified in the Interim Report, the Final Report recommendations are designed to respond to this.
- Service provider standards (Rec 48) call for partnering with LLE-led organisations to become standard practice, with LLE "involvement and partnering" as part of standards for leadership, accountability and governance. Alongside this, standards call for partnering with consumers "including the organisations that represent them" and "supporting them to lead and participate".
- Of currently existing LLE-led organisations, VMIAC and Tandem will play a key role in implementation of the Commission's recommendations:
    - "Fostering the leadership capabilities of advocacy organisations and peak bodies, including the Victorian Mental Illness Awareness Council and Tandem, will be crucial. These organisations play a pivotal role in supporting individuals and other organisations to engage, advocate and implement reform. Through times of major change, these organisations will be an important source of guidance and support. It is likely that their role will also intensify as government and implementers look to partner with them to harness their expertise and relationships across the sector. The Commission encourages the Victorian Government to support these organisations through adequate and stable resourcing, tailored supports and opportunities for professional development and training."[13]

LLE-led solutions for specific experiences and populations

- **Crisis response:** there was particular emphasis on developing and rolling out statewide consumer-led responses for people experiencing suicidal crises (Rec 9), with consumer-led drop-in/crisis respite being mandated for each region.

[11] Final Report Vol 5, Ch 37 p256.

[12] Interim Report, Part 5, p500.

[13] Final Report, Vol 5, Ch 37, p205.

Notably, while the Commission recommends LLE-led crisis respite for adults, for young people it recommends a youth co-designed version where the contract is held by an NGO that provides youth-specific services instead of being LLE-led.

- **Trauma supports:** LLE-led services should be a core part of trauma supports, including digital peer-led support platform for consumers with lived experience of trauma to access peer support networks (Rec 23)
- **Priority populations:** There were further recommendations about “community-led” solutions (e.g. Switchboard navigation services for LGBTQI+) that are explored further in the partnerships section.

LLE workforce and leadership

LLE workforce and leaders are key components of service delivery and system change.

Recommendations related to LLE workforce and leadership beyond named roles (named LLE leadership roles are in the following section).

Leadership is a broad term and it is important that working definitions are developed. As a starting point leadership can be seen to include those in a group or organisation who influence or guide other individuals, teams, organisations and systems.

Leadership and workforce have been grouped together for this analysis as they are heavily integrated. This is particularly true for LLE roles, where the LLE workforce, in line with the Commission's vision, are intended not just to deliver services, but to be drivers of systems change. As such, all members of the LLE workforce are leaders in systems change.

However, there are differences in influence and power amongst LLE leadership roles. For the purposes of this analysis, LLE leadership focuses on 'traditional' leadership roles including governance, executive management, operational management and thought leadership.

Recommendations

Int. Rec 6	**Lived experience workforces' expansion and development** Co-produced program which develops and implements: A. Continuing learning and development pathways B. New organisational structures, capability and programs within services to enable practice supports (inc. coaching and supervision) C. Mandatory organisation readiness training for senior leaders and resources for staff D. Ongoing accountability mechanisms for measuring organisational attitudes and experiences of LLE workforces
Rec 5	**Peer support, education and self-help as core function in the Community Model** Every Local/AMH&W service should provide services with peer support throughout, including: A. Education, including Recovery Colleges at each AMH&WS B. Peer support C. Self-help
Rec 23	**Trauma support within VCC's Statewide Trauma Service** Peer workers will work collaboratively with clinicians, trauma experts, consumers to: A. conduct research B. develop and deliver education and training to support MH workforce C. Digital peer-led support platform for consumers with lived experience of trauma to access peer support networks

	D. Coordinate access to trauma expertise, including secondary consult for clinicians and peer workers
Rec 26	**LLE employed in Suicide Prevention and Response Office** A. Employ people with LE of suicidal behaviour and family members B. Work with LE to co-produce, implement and monitor Suicide Prevention and response Strategy
Rec 28 & 30	**Developing system-wide roles for Consumers and Family/Carers** A. Develop key LLE roles across the system B. Elevate LLE leadership in decision-making about policies and programs C. Develop and support LLE leadership capabilities through learning opportunities D. LLE leadership development supported by MH&W Commission Note: these recommendations supersede Int Rec 9 for MHRV to employ and commission LLE to respond to recommendations
Rec 31	**Carer-led centres in each region (8 total)** A. Provide tailored information and connect Family/Carer with supports B. Provide funds for immediate practical needs (e.g. short term respite) C. Deliver Family/Carer peer support groups
Rec 31	**Statewide Family/Carer peer call-back service for suicidal behaviour** A. Family/Carer warmline to provide peer support for family/carers with a consumer experiencing suicidal ideation and behaviour
Rec 50	**Federal and State partnerships** A. Through National Mental Health and Suicide Prevention (MH&SP) agreement, raise the profile of LE leadership
Rec 54	**Eliminating seclusion and restraint** A. MH Improvement Unit in Safer Care Victoria works with service providers to increase consumer leadership in all activities to reduce seclusion and restraint
Rec 55	**Reducing compulsory treatment** B. MH Improvement Unit in Safer Care Victoria works with service providers to increase consumer leadership in all activities to reduce compulsory treatment
Rec 65	**Innovation funding for consumer-led initiatives** A. The new innovation hub administering the mental health innovation fund must fund consumer-led initiatives

Assertive commentary or soft recommendations	
Int. Rec 7	**Mental health leadership network** A. Establish "a 'mental health leadership network' with representation across the state and the various disciplines, including lived experience workforces, supported to participate collaboratively in new learning, training and mentorship opportunities"
Rec 8	**Peer workers in crisis outreach services** 1. Expand crisis outreach to include "support from a clinician and a non-clinical worker such as a peer worker"
Rec 11	**New models of care for bed-based services** A. Recommends investing in a "wide range of time-limited and flexible residential respite services" including Healing Place (Rec 5)
Ch 19	**Family/Carer crisis peer support** A. "Wherever possible, dedicated peer worker roles should be established for families and others involved in the crisis."

Narrative and directions

The diagram below outlines the key narrative and directions from the above recommendations, with each considered in detail:

LLE Leadership is key to systems change.

- LLE Leadership is a key enabler of systems change as it brings those with greatest direct knowledge of the issue into key, substantive roles with decision-making authority.
- LLE leadership is needed across the sector, and needs to be mandated within key decision-making bodies, e.g. VCC, MH&W Commission, Regional Boards, etc.
- LLE leadership needs to be embedded at the highest authority and integral to system oversight, with independence from government.

- Both Consumer and Family/Carer voices are needed, and work alongside each other in key leadership roles.

LLE leadership needs investment and support

- Given the emergent nature of LLE leadership, significant investment in development of leadership pathways, networks and professional development are required.
- MH&W Commission and the Department of Health will have key role in developing and supporting programs to establish thriving LLE leadership.
- Alongside this, the Consumer Agency will play a key role in developing consumer leaders to gain access to opportunities to develop consumer-led organisations, as well as providing training to mainstream organisations to implement LLE leadership (although this function is secondary to establishing LLE-led organisations)

New entities to be exemplars of LLE leadership.

- New entities: VCC, MH&W Commission, LLE Branch, Consumer Agency and Carer-led centres will be world-leading exemplars of LLE leadership.
- Their LLE leadership standards will drive wider system change for full and effective participation for LLE.
- The Victorian Collaborative Centre (Collaborative Centre) in particular presents a "unique opportunity to place people with lived experience at the centre of service design, delivery, research and evaluation."[14]
- Alongside but separate to the Collaborative Centre is the Innovation Body - which must fund consumer-led initiatives and "ensure the funding and activities for…innovation are aligned with system needs and expectations, including a commitment to consumer leadership."[15]

LLE leadership is to be especially elevated where human rights are engaged.

- Consumer leadership in services is key to reduction in compulsory treatment (Rec 55) and elimination of seclusion and restraint (Rec 54); "consumer leadership in efforts to eliminate seclusion and restraint is essential for change."[16]
- This will be supported by the MH&W Commission including consumer leadership in overseeing the use of compulsory treatment and restrictive practices.

LLE should be leaders in system innovation and research.

- The Collaborative Centre, with LLE on its board and in the Co-Director role, is charged with having LLE-led research as a priority area, and to grow the body of consumer-led research.
- The Commission recommends that "proactive efforts must be undertaken to support and build the capabilities of consumers as leaders of research and innovation", ensuring that consumer leaders have a "senior presence in the governance of innovation,

[14] Final Report, Vol 5, Ch 36, p138.

[15] Final Report, Vol 5, Ch36, p174.

[16] Final Report, Vol 4, Ch 31, p346.

implementation and evaluation responsibilities" including influencing "how funding is shared."[17]

- The new 'mental health and wellbeing innovation fund', administered by the new innovation body is required to "fund consumer-led initiatives"[18] as well as have lived experience experts as partners on its MH&W collaborative network.

LLE workforces encompass a broad range of roles that need to be defined.

- The Commission saw that LLE workforces encompassed a broad range of roles "including providing support directly to consumers, families, carers and supporters through peer support or advocacy, or indirectly through leadership, consultation, system advocacy, education, training or research."[19]

- They saw a gap that these roles have "a distinct value and purpose that should be clearly articulated and delineated within services and the broader system."[20]

LLE workforces are a vital part of the new system.

- The Commission found "lived experience workforces are critical to the contemporary mental health and wellbeing system"[21], with the Commission in its Interim Report having "committed to lived experience workforces being a core part of the new mental health and wellbeing system."[22] It found currently Victoria has a small but growing workforce, with more consumer than carer roles.

- Recommendations call for substantial uplift, elevation and proliferation of the LLE workforces as a core part of the reformed system, with substantial increase as part of Locals and AMH&WS; "the provision of peer support programs through the employment of peer workers in adequate numbers will become standard practice in the Local Mental Health and Wellbeing Services and Area Mental Health and Wellbeing Services"[23]

- Alongside this, family/carer peer support will be available statewide through the family/carer-led hubs, the warmline service, and Locals and AMH&WS. Notably there will be more reliance in this workforce on volunteer peer support workers. The Commission also recommends that "over time, most workers in the family-and carer-led centres will be family and carer peer workers."[24]

Peer workers are key in crisis response services.

- The Commission saw peer work roles as being particularly important in crisis response settings, where "including peer workers in crisis outreach teams will help embed compassionate cultures and practices."[25] They recommended that CAT Teams should include non-clinical support workers, "ideally a peer worker."[26]

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[17] Final Report, Vol 5, Ch 36, p179.

[18] Final Report, Vol 5, Ch 36, p173.

[19] RCVMHS Final Report, Vol 4, Ch 33, p457.

[20] RCVMHS Final Report, Vol 4, Ch 33, p457.

[21] RCVMHS Final Report, Vol 4, Ch 33, p464.

[22] RCVMHS Final Report, Vol 4, Ch 33, p497.

[23] RCVMHS Final Report, Vol 1, Ch 7, p421.

[24] RCVMHS Final Report, Vol 3, Ch 19, p108.

[25] RCVMHS Final Report, Vol 1, Ch 9 p530.

[26] RCVMHS Final Report, Vol 1, Ch 9 p530.

- Alongside this, “wherever possible, dedicated peer worker roles should be established for families, carers and supporters and others involved in the crisis.”[27]

Carer peer workers are key in child and youth services.

- The Commission makes specific recommendations for an increase in the number of family/carer peer workers in the following areas:
    - Infant, Child and Family Area MH&W Services
    - Youth Area MH&WS

Vision for LLE-led services need to be incorporated into workforce development.

- As discussed in the ‘LLE-Led organisations’ section above, the Commission envisioned that LLE-led services would be a significant part of the service mix. The Commission recommends coordinating workforce development efforts in light of this, including when “increasing overall capacity and adjusting composition, the Victorian Government should take into account the Commission’s priorities for the new system including… enhanced service delivery approaches including mental health and wellbeing services led by people with lived experience.”[28]
- For example, the consumer-led ‘safe spaces’ were identified as an area that would “require a considerable increase in the number of adequately skilled and experienced lived experience workers for both management and peer support roles.”[29]
- The Commission saw the importance of setting the workforce and services up for success - “it is important that new peer respite services are not established until appropriately qualified and skilled peer workers can be recruited to leadership roles.”[30]

LLE workforces don’t just provide services but drive systems change.

- LLE workforce is needed not just to provide services but also to shift the wider culture of service delivery to be more recovery-oriented; “the value of lived experience workforces and the need to expand their roles and further embed their expertise throughout the system, including clinical mental health services, is readily apparent.”[31]
- For example, the Commission notes that “experts have advised the Commission that a strong and visible role for peer support workers can help reduce the use of seclusion and restraint”[32]
- Critical mass of empowered LLE is needed to achieve this cultural change.

LLE-designed and delivered service(s) are also part of workforce development.

- Interim Report:
    - “A service designed and delivered by people with lived experience will generate opportunities to broaden the reach and influence of the consumer–family–carer

[27] RCVMHS Final Report, Vol 1, Ch 9, p523.

[28] RCVMHS Final Report, Vol 4, Ch 33, p496.

[29] RCVMHS Final Report, Vol 4, Ch 33, p494.

[30] RCVMHS Final Report, Vol 1, Ch 9, p553.

[31] RCVMHS Interim Report, Vol 1, Part 5, p501.

[32] RCVMHS Final Report, Vol 4, Ch 31, p347.

workforce by increasing its overall visibility and elevating its status. For example, an evaluation of the Peer Operated Service in Queensland reported that hospitals and health services in the local area increased the employment of peer workers in their own mental health programs, in part because of the success of the service delivered by people with lived experience."

Many people in non-LLE roles have lived experience.

- A high percentage of the workforce have lived experience, with the workforce survey (2,920 workers from across the sector) showing 43% had direct experience of mental illness and 38% with experience as a family/carer. Overall, 66% identified themselves as having lived experience.

- In this context lived experience was talked about as being a benefit for workers in non-LLE roles to make them more empathic. From a system level the Commission found that acknowledging lived experience exists throughout the sector "can help create a strong foundation for a compassionate and collaborative mental health and wellbeing system".[33]

- Alongside this the Commission also described the significant stigma that means many in the workforce do not disclose their lived experience for fear of real or perceived judgement and impact on their career. This was also seen as a recruiting issue as there were not examples of people with lived experience being well supported in their roles, e.g. as a paramedic.[34]

LLE workforces lack the infrastructure needed to support them.

- Considerable work needs to be done to support the LLE workforces and also clinical workforce and services to be able to support and understand the value of LLE workforces. The final report articulated four domains in which LE workforces need to be supported to take on a central role in the new system, as seen below.[35]

- The Commission also supported "all efforts to raise the profile" of LLE workforces, including "mechanisms to promote professional recognition of LLE workforces"[36]

[33] RCVMHS Final Report, Vol 4, Ch 33, p464.

[34] RCVMHS Final Report, Vol 4, Ch 33, p464.

[35] RCVMHS Final Report, Vol 4, Ch 33, p540.

[36] RCVMHS Final Report, Vol 4, Ch 33, p541.

Figure 33.12: Transitioning to better supported, recognised and expanded lived experience workforces

Figure 2 Transitioning to better supported, recognised and expanded lived experience workforces[37]

There is a unique role for peer workforce in key priority populations and areas.

- **LGBTQI+ communities:** funding for Switchboard (Rec 34)
- **Trauma supports:** digital peer-led trauma support platform (Rec 23)
- **Aboriginal-led services:** e.g. Healing Centres, although this is considered in this report as 'community-led' solutions rather than peer workforce given the Commission's ambition toward Aboriginal self-determination in the recommendations.

[37] RCVMHS Final Report, Vol 4, Ch 33, p540.

Named LLE leadership roles

LLE leaders are in key, substantive positions at all parts and levels of the system and are supported to drive change

Named and specific key LLE leadership roles that are designed to drive systems change and full and effective LLE leadership and participation.

Recommendations

Int. Rec 1	**Victorian Collaborative Centre** A. Lived experience (Consumer and Family/Carer) on Board B. Co-Director with LE (Consumer) C. Drive exemplary practice for full and effective participation of people with LE across the MH system
Rec 4	**Regional Boards** A. Consumer and Family/Carer on Regional Boards B. Consumer and Family/Carer on Regional Multiagency Panels
Rec 29	**Consumer Agency** A. Chaired by Consumer, Board with majority LE (Consumer), majority of positions are LE B. Deliver training to support development of peer-led organisations C. Develop and deliver LE-led MH&W services D. Facilitate co-location, shared resourcing, learning, partnerships and networks between LE-leaders and LE-led organisations
Rec 44	**MH&W Commissioners** A. Consumer and Family/Carer Commissioners B. Support LLE to lead and partner in improvement of the system
Rec 45	**Department of Health LLE Branch** A. Bring MHRV into DH and ensure division employs LLE in multiple, substantive positions, including leadership positions

Narrative and directions

The diagram below outlines the key narrative and directions from the above recommendations, with each considered in detail along with Table 1 showing how LLE leaders will be placed in significant positions of power, encompassing leadership of system oversight functions.

Named LLE leadership roles to play key part in systems change.

Named roles are only the beginning for LLE leadership

Named LLE leadership roles to play key part in systems change.

- Table 1 below shows where named LLE leader roles will be in significant positions of power, encompassing leadership of system oversight functions such as commissioning, planning, monitoring, improvements, stewardship etc.

Named roles are only the beginning for LLE leadership.

- "In addition to these nominated roles specified in other recommendations in this report, it is imperative that proactive efforts to develop key roles across the mental health and wellbeing system for people with lived experience of mental illness or psychological distress continue."[38]

[38] RCVMHS Final Report, Vol 3, Ch 18, p15.

Table 1 - LLE named leadership roles and system oversight functions.

	DH	**VCC**	**MHWC**	**Regional Boards**
LLE engagement in entities	LE Branch with LLE in key leadership roles and throughout division	Consumer and Family/Carer on Board and LLE Co-Director Exemplar of LLE leadership	Consumer and Family/Carer Commissioners Exemplar of LLE leadership	Consumer and Family/Carer on Regional Boards
System oversight functions				
Commissioning	✓ statewide	✓		✓ per region
Demand and capital planning	✓ statewide			✓ per region
Workforce planning	✓ statewide			✓ per region
Monitoring and improvement	✓ statewide		✓ inc. complaints	✓ per region
Quality and safety accountability			✓	
Initiate enquiries and compel data from Gov			✓	
MH&W Outcomes Framework			✓ Develop and report on	
Monitor RC implementation	✓		✓	✓ Locals and AMH&WS
Elevating LLE leadership and Family/Carer inclusion	✓ Develop LLE leadership	✓ Drive LLE inclusion at VCC	✓ Develop LLE leadership	
Conduct evaluations				✓
Maintain navigation				✓

information				
System stewardship	✓	✓	✓	✓
Academia and research		✓		

LLE partnership

People with LLE and LLE-led organisations are genuine partners in all aspects of the system

Recommendations where initiatives are designed and/or delivered with LLE in consultation, co-design, co-production, collaboration with LE-led entities, or community-led, for example:

- Rec 12: new CCU and SECU services to be co-designed with LE
- Rec 9: new 'safe spaces' to be designed in collaboration with the Consumer Agency

Recommendations

Partnership recommendations are ordered from the highest on Arnstein's ladder[39] to the lowest. Arnstein's ladder is an influential framework for understanding the level of citizen-control and power sharing in policies and programs by public institutions.

Community-led recommendations Resourcing organisations to design solutions themselves	
Rec 27	**Suicide Prevention initiatives for Aboriginal people** A. Enabling Aboriginal people to design culturally safe 'community gatekeeper training' for Aboriginal people
Rec 33	**Supporting Aboriginal social and emotional wellbeing** A. Resource the Social and Emotional Wellbeing Centre to establish 2x co-designed healing centres B. Resource ACCHOs to commission Aboriginal social and emotional wellbeing services for children and young people
Rec 34	**Improving accessibility for diverse communities** A. Enable diverse communities and community-led organisations to design and deliver mental health information and awareness campaigns, and assist their communities to navigate the system B. Provide recurrent funding to Switchboard to deliver the Rainbow Door program to assist LGBTQI+ community to navigate and access the system
Rec 41	**Anti-stigma community grants program** A. Government to deliver an anti-stigma grants program to support community-led organisations and community members to deliver projects that challenge stigma
Rec 64	**Consumer-led innovation**

[39] *Ladder of citizen participation*. Organizing Engagement. (2020, January 15). https://organizingengagement.org/models/ladder-of-citizen-participation/

	A. A new mental health and wellbeing innovation fund that must fund consumer-led initiatives

Partnerships/collaboration recommendations	
Rec 1	**MH&W Outcomes Framework** A. Created in partnership with LLE, MH&W Commission and government departments (Department of Health, Department of Premier and Cabinet, Department of Treasury and Finance) B. MH&W Commission to monitor the Framework and report annually on progress
Int. Rec 5	**Healing Place: LE-designed and delivered residential service** E. Delivered and managed by majority LE workforce F. Facilitated through partnership with community health service and/or AMHS G. Co-produced with LE and provides short-term treatment, care and support H. Evaluation to guide the expansion of similar services
Rec 9	**Developing 'safe spaces' and crisis respite** A. In collaboration with the Consumer Agency (rec 29) establish: a. One adult drop in/crisis per region (8x total) b. Four youth safe spaces across the state, comprising a mix of drop in/crisis co-designed with young people
Rec 23	**Trauma support within VCC's Statewide Trauma Service** Peer workers and LLE of trauma will work together with clinicians, trauma experts to: A. Conduct multidisciplinary and translational trauma research B. Develop and deliver education and training to supports the MH workforce to deliver trauma-informed care C. Develop and oversee digital peer-led support platforms for consumers to access peer support networks D. Coordinate access to trauma expertise, including secondary consult for clinicians and peer workers
Rec 27	**Consumer-led research and evaluation** A. Chief Officer for Mental Health and Wellbeing must commission and facilitate research and evaluation into including consumer-led research and evaluation
Rec 33	**Supporting Aboriginal social and emotional wellbeing** A. Resource VACCHO, in partnership with a Child and Youth Area Menal Health and Wellbeing Service, to design and establish a culturally appropriate, family-oriented service for infants and children who need intensive social and emotional wellbeing supports

Rec 48(2)	**Supporting new and existing service providers** A. Service provider standards at full-maturity call for LLE to be partners and leaders
Rec 57	**Workforce strategy, planning and structural reform** A. Department of Health to encourage collaborative engagement and partnerships with relevant workforce stakeholders in implementing recommendations
Rec 58	**Workforce capabilities and professional development** A. Enable the VCC, in collaboration with training providers, MH&W services, people with LLE to coordinate learning and professional development activities across the workforce Note: this recommendation would be lowered to co-design if it wasn't with the VCC. As the VCC is LLE-Led it elevates its level of participation.
Rec 59	**Workforce safety and wellbeing** A. Work with service providers, workers ("including lived experience workers"), unions, representative and professional bodies to set expectations and implement measures to support professional wellbeing of the workforce
Rec 64	**Lived experience partnership in innovation** A. New collaborative networks must be "made up of a flexible and evolving group of partners from different fields of national and international expertise…including lived experience"[40]

Co-produce recommendations	
Int Rec 1	**Victorian Collaborative Centre** A. Bring people with LE together with researchers and experts in clinical and non-clinical to develop and provide services, conduct research and disseminate knowledge B. Drive exemplary practice for the full and effective participation and inclusion of people with LE across the MH system
In Rec 6	**Lived experience workforces expansion and development** Co-produced a program which develops and implements: A. Continuing learning and development pathways B. New organisational structures, capability and programs within services to enable practice supports (inc. coaching and supervision) C. Mandatory organisation readiness training for senior leaders and resources for staff

[40] RCVMHS Final Report, Vol 5, Ch 36, p173.

	D. Ongoing accountability mechanisms for measuring organisational attitudes and experiences of LLE workforces
Rec 6	**System navigation and self-help** A. Co-produce with LLE a website that provides clear, up-to-date information about the MH&W system that helps users: a. Understand their MH needs b. Identify services and supports c. Access online self-help resources
Rec 26	**Suicide Prevention and Response (SP&R) Strategy** A. Co-produce SP&R strategy in new SP&R Office with people with lived experience of suicidal behaviour, family/carers and lived experience of bereavement by suicide
Rec 27	**Suicide prevention aftercare service for LGBTQI+** A. Co-produce an aftercare service for LGBTQI+ following a suicide attempt

Co-design recommendations	
Int Rec 2	**Bed-based service expansion** A. Design and establishment of additional beds should be co-designed with people with lived experience
Rec 9	**Developing 'safe spaces' and crisis respite** A. In collaboration with the Consumer Agency (rec 29) establish: a. Four youth safe spaces across the state, comprising a mix of drop in/crisis co-designed with young people
Rec 12	**Developing and delivering new CCU and SECU models of care** A. Co-design with consumers, clinicians and relevant NGOs and services a. New community rehabilitation model of care and deliver at a CCU demonstration site b. New intensive rehabilitation model of care and deliver at a SECU demonstration site B. Subject to evaluation and required adaptation, apply these models to existing CCU and SECUs and enhance and expanded needed infrastructure
Rec 32	**Supporting young carers** A. Fund a NGO such as Satellite Foundation to co-design and expand the range of supports for young carers
Rec 43	**Future review of the mental health laws** A. Co-design terms of reference for a review of mental health laws 5-7 years after enactment of the MH&W Act

Rec 52	**Improving quality and safety of MH&W services** A. Co-design quality and safety improvement programs with people with lived experience
Rec 54	**Eliminate seclusion and restraint** A. Chief Officer for MH&W to develop and lead strategy to reduce seclusion and restraint B. Enable MH Improvement Unit in Safer Care Victoria to co-design with services and people with lived experience a range of programs and supports aligned with the strategy that focus on: a. Working with each service to investigate local data and practices to identify priority areas of change b. Making workforce training available for services c. Continuing to support services to embed SafeWards
Rec 61	**Information sharing** A. Co-design and implement a consumer consent approach with consumers so that the system "will inform service providers, families, carers and supporters involved" in a person's treatment about "how consumer information can be collected, used and shared."

Consultation recommendations	
Rec 9	**Developing 'safe spaces' and crisis respite** A. Establish a crisis stabilisation facility, in consultation with lived experience, led by a public health service/hospital in partnership with a NGO that delivers wellbeing supports
Rec 21	**Redesigning bed-based services for young people** A. Formally review the Youth Residential Rehabilitation Program in consultation with young people and family/carers

Narrative and directions

The diagram below outlines the key narrative and directions from the above recommendations, with each considered in detail along with Table 2 showing overview of partnerships in action delivering on the recommendations.

LLE plays a key role in the system.

Service provider standards are designed to embed partnership with LLE over time.

Specific communities need to be empowered to create solutions

Consumer Agency is a key collaborator.

Victorian Collaborative Centre is an exemplar for LLE research partnerships.

The more acute the service, the less empowered the partnership.

Specific lived experience is needed for particular services.

LLE partnership plays a key role in the system.

- People with LLE, LLE leaders and LLE-led organisations (e.g. VMIAC, Tandem, Consumer Agency, VCC, MH&W Commission) should play a key role in the implementation of recommendations, design and delivery of services, policies, as well as oversight and monitoring.

Service provider standards are designed to embed partnership with LLE over time.

- Service provider standards include several 'domains' related to LLE partnership, including the "consumer, family, carer and supporter partnerships and community engagement" and "leadership, accountability and governance"[41] domains.

- In relation to LLE and community engagement domain, the service provider standards call for services at full maturity to "partner with consumers, families, carers and supporters, including through opportunities for co-production" as well as that services are "partners with diverse consumers, families, carers and supporters (including the organisations that represent them), supporting them to lead and participate."[42]

- Service provider standards also require at full maturity under "leadership, accountability and governance" domain for services to have "strong governance, a unifying vision and strategy, and a culture of consumer, family, carer and supporter involvement and partnering."[43]

- These standards are designed to be an overarching mechanism to ensure that LLE partnership is embedded throughout the sector as it continues on its reform journey.

Specific communities need to be empowered to create solutions.

- Specific communities need to be empowered to create their own solutions - in particular Aboriginal, culturally diverse and LGBTQI+ communities.

- Solutions for Aboriginal communities should move towards Aboriginal self-determination, so recommendations call for resourcing and enabling Aboriginal-led organisations.

Consumer Agency is a key collaborator.

- There are a number of recommendations in which the Consumer Agency is a key collaborator e.g. Rec 9 - 'safe spaces' but it is also named as a contributor in assertive commentary throughout the report to be a partner for example in providing training and support for services to implement LLE leadership.

Victorian Collaborative Centre is an exemplar for LLE research partnerships.

- The Collaborative Centre is designed to be world-leading centre with a priority focus on research co-produced with LLE:

    - "Collaborative Centre to have a priority focus on research that is co-produced and led by people with lived experience of mental illness or psychological distress, with a focus on experiential knowledge, as well as the creation of innovation

[41] RCVMHS Final Report, Vol 4, Ch 28, p129.

[42] RCVMHS Final Report, Vol 4, Ch 28, p129.

[43] RCVMHS Final Report, Vol 4, Ch 28, p129.

networks supported by flexible funding to expand and diversify innovative practice across the mental health and wellbeing system. The recommended innovation collaborative networks will include a flexible and evolving group of partners, including people with lived experience of mental illness or psychological distress, ensuring they have influence over the design and development of promising innovation."[44]

The more acute the service, the less empowered the partnership.

- In broad terms, the less acute the service, the more empowered communities are, e.g. system navigation website to be co-produced with LE, whereas crisis stabilisation facility to be done in consultation with LE. Notable exceptions are for priority populations, e.g. Aboriginal specific services where self-determination is the goal.

Specific lived experience is needed for particular services.

- Recommendations support that lived experience should be tailored for design of program or initiative, e.g. trauma service, suicide prevention strategy and programs.

Table 2 - Overview of partnerships in recommendations

	Consultation	**Co-design**	**Partnership/ co-production**	**Community-led**
LLE engagement in entities	Design work done in consultation with LLE	Co-designed with LLE	In partnership with or co-produced programs	Government "resources" or "enables" a NGO to undertake the work
Community supports, access and navigation				
Aboriginal SP community gatekeeper training				✓
MH information and navigation for diverse communities				✓
System navigation and self-help			✓[45]	
Anti-stigma community grants program				✓

[44] RCVMHS Final Report, Vol 3, Ch 18, p29.

[45] Risk that without partnership with LLE-led organisations that this recommendation becomes in consultation rather than partnership.

System oversight, strategy and regulation				
MH&W Outcomes Framework			✓ oversight by MH&WC	
Suicide Prevention strategy			✓	
ToR for review MHAct		✓		
Service design and development				
Establish ‘safe spaces’			✓ partner with Consumer Agency	
Establish Aboriginal healing centres				✓
Establish Aboriginal intensive child supports			✓	
Design expansion of bed-based services		✓		
Design CCU and SECU models		✓		
Design supports for young carers		✓		
Establish crisis stabilisation service	✓			
Redesign youth residential rehab	✓			
Quality and safety				
Q&S improvement programs		✓		
Strategy to reduce		✓		

restrictive practices				
Research and innovation				
VCC LLE co-produced research			✓	
MH&W Innovation Fund to fund consumer-led initiatives			✓	
Chief Officer for MH&W must commission consumer-led research and evaluation			✓	
Workforce				
Trauma training from VCC			✓	
DH Workforce strategy			✓[46]	
VCC-led workforce training			✓[47]	
Workforce safety & wellbeing			✓[48]	
LLE workforce development			✓	

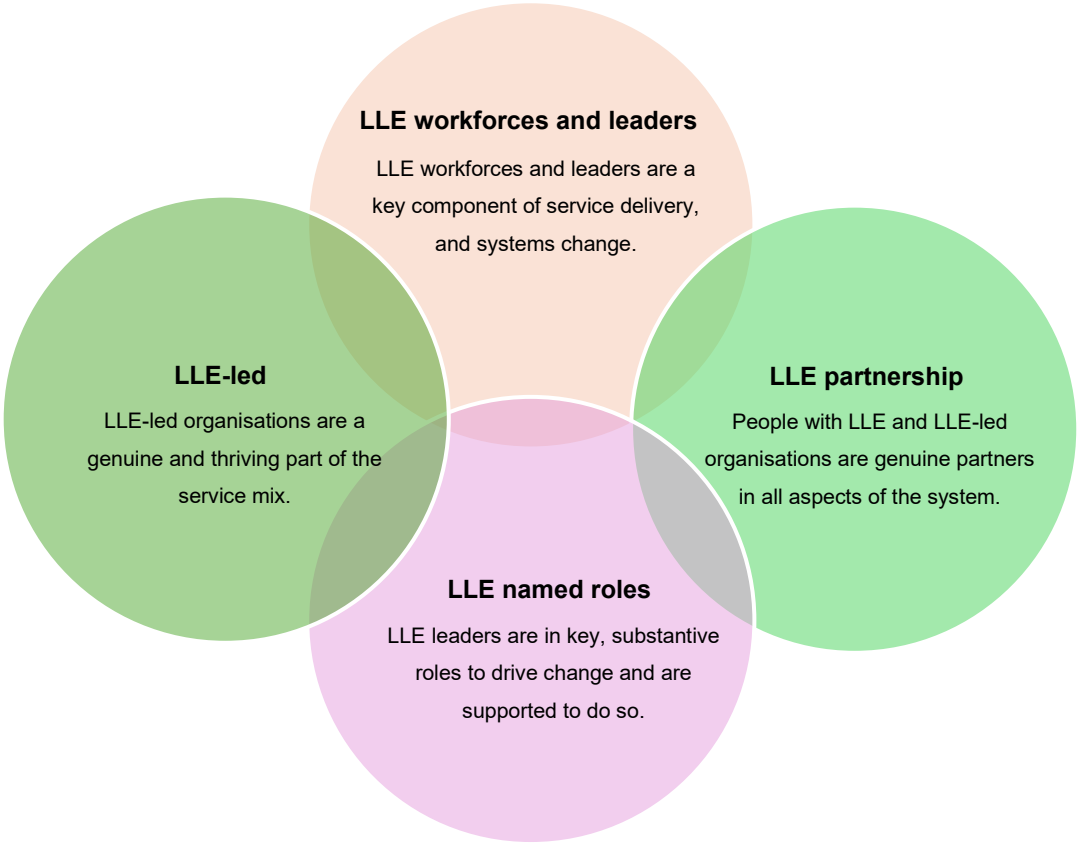
[46] Given lack of LLE workforce representative bodies this is likely to be done in consultation rather than partnership.

[47] Given lack of LLE workforce representative bodies this is likely to be done in consultation rather than partnership.

[48] Given lack of LLE workforce representative bodies this is likely to be done in consultation rather than partnership.

Gaps in the Royal Commission recommendations

This section provides the gaps identified in the RC analysis, presenting four overarching areas of gaps then gaps within each of the four areas of the vision - Figure 1 of this report, copied here:



Overarching gaps in the Royal Commission recommendations

Definitional work needs to be done.

- An LLE leadership strategy needs to include definitions and commentary on key terms like leadership, workforce (e.g. to make sure we include volunteers and those in education and training with the intention of joining the workforce) and partnership.

Focus on Mental Health Service System, exclusion of AOD.

- Given the focus of the Terms of Reference for the Royal Commission and previous government arrangements, the recommendations focus almost completely on design of the mental health system, with AOD included where there is overlap for people experiencing both addiction as well as mental health issues. This is a clear oversight given the now inclusive focus of the implementation of the reforms.

Lack of clarity around how soft recommendations would be achieved

- Throughout the Royal Commission recommendations there are instances of assertive commentary or suggestions that directly relate to LLE leadership, workforce and partnership.

    - e.g. Rec 8 **-** expand crisis outreach to include “support from a clinician and a non-clinical worker such as a peer worker”.

- Given these are not mandated recommendations and given the barriers to implementing LLE leadership and workforce, there is significant risk these would not occur organically.

LLE-led organisations

The diagram below outlines the key gaps identified in recommendations about LLE-Led organisations with each considered in detail below:

Lack of clarity on governance arrangements and their impact

- There is a focus on LLE-led services, yet many of the recommendations do not specifically clarify the best-practice governance arrangements for peer-led services.
- The interim report describes the difference between LLE-led and LLE-delivered services:
    - "*Consumer-led services.* This refers to services that are delivered and managed by consumers for consumers. An example is a residential service that employs a workforce consisting of a majority of people with lived experience under the leadership of an organisation (including its board and governance structures) that is also led by people with lived experience.
    - *Consumer-delivered services.* This refers to services that are delivered by consumers and that sit within the broader governance arrangements of an organisation that is not consumer-led. An example is a drop-in centre that employs people with lived experience but sits within the broader governance structures of an area mental health service or hospital."
- For example, a key LLE recommendation is for one consumer-led 'drop-in' service per region[49], modelled off of the Safe Haven Cafe. The example given is the St Vincent's Hospital Safe Haven Cafe. Yet there is no mention of the governance arrangements for this service, or the impact this might have on the service being consumer-led or consumer-delivered.
- This happens throughout the report in different recommendations where governance arrangements are opaque. It is particularly important for LLE-led services that don't have this level of governance detail, because these are likely to have funding that will be competitive and likely to be pursued by larger established providers. Often in these sections the Consumer Agency is mentioned as an enabler of these services, but there does not appear to be clarity as to how this will be actioned or mandated.

[49] Recommendation 9 calls for each region to have one adult consumer-led 'drop-in' service per region, *or* a crisis respite, which *could* include a peer-led crisis respite.

- Regional Boards and DH are designed to support newer providers, particularly LLE-led providers, to be able to meet the service standards to be able to hold these kinds of contracts, but DH would need to proactively take on this leadership role and Regional Boards would need to be upskilled and resourced to support LLE-led providers.

- The current absence of the Consumer Agency is also a gap as they were designed to play a key role in supporting the establishment of these LLE-led organisations.

- Another example is the digital peer-led support platform. For example, VCC is recommended to create a digital peer-led support platform, yet the governance arrangements for this service will not necessarily lead to a peer-led service.

- It recommends that the digital peer-led support platform is "run by consumers and peer support workers through the Statewide Trauma Service."[50] The service however will be embedded in the VCC and the provider will be selected through EOI process, where the government must "ensure that the applicant works to establish genuine, collaborative partnerships with: a diversity of consumers, peer and lived experience workers…"[51]. The end result may or may not lead to a truly consumer-led service as described above, but instead a consumer-delivered service.

Service provider standards only provide soft incentives for LLE-led services

- Service provider standards are designed to ensure more LLE-led organisations can become part of a diverse service mix, yet service provider standards don't mandate this and so there is no accountability as to the type and extent of this happening.

- Alongside this, practical understandings of what partnership/leadership of LLE looks like could mean that service provider standards become a low bar to attain, and Regional Boards and DH may not understand and/or enforce LLE leadership and partnership.

- DH/Regional Boards don't appear to have other incentives for commissioning to LLE-led organisations in future or the necessary education and training to understand the role of this emergent part of the service mix. There is an expectation that having LLE on Regional Boards will ensure fidelity to Royal Commission intention re: LLE-led services but as a finer detail this is likely to be lost in the broad remit of the Regional Boards' responsibilities.

- There are several soft recommendations for LLE-led services (e.g. Rec 5 - community model and Int Rec 5 - expanding LLE-led residential service) but given the emergent nature of these areas of service delivery there is a high possibility that these suggestions would not be followed.

- Where there are soft recommendations to expand LLE-led services, it is unclear what organisations or structures (if any) would guide and ensure the expansion of the LLE-led and delivered service.

Lack of clarity on how the Consumer Agency would guarantee development of consumer-led organisations with significant service provider contracts

- Consumer Agency is designed to be an enabler of LLE-led services but lacks brokerage power for how to ensure consumer-led organisations can gain the service provider

[50] RCVMHS Final Report, Vol 2, Ch 15, p383.

[51] RCVMHS Final Report, Vol 2, Ch 15, p383.

contracts needed to establish a thriving network of peer-run organisations in the service mix.

- What is needed to ensure the success of the Consumer Agency given it doesn't have the network, history or funding of the organisation the Commission took inspiration from, the Pride Centre?

Lack of mandate for consumer-led services statewide

- One of the most transformative recommendations, the new community model, includes peer support as a core part of the community model statewide, but as yet there is not mandate that any of these services include consumer-led organisations - there is a danger that these large contracts are taken by non LLE-led services when there is an opportunity to use this significant part of system uplift and reform to increase capacity and quality of peer-led organisations to deliver contracts.

- Danger that LLE-led services will not become a genuine option due to a lack of mandate to establish or expand services, so will remain as struggling pilot programs.

- Carer-led centres have already been commissioned and are up and running, whereas there exists no such mandate for consumer-led services, and lack of clarity around how the Consumer Agency would ensure a thriving network of similar services in the consumer space.

- Even the most promising area for peer-led responses – crisis response – could be downgraded in terms of being LLE-led. It is recommended all peer services be developed in collaboration with the yet-to-be-established Consumer Agency, and with an NGO. Beyond this, the recommendation calls for one drop-in or crisis respite per region (where crisis respite has peer-led as one option). This could mean that these consumer-led options could result in one 'safe haven cafe' model style service, where the contract is held by a public hospital, per region, and no other innovative peer-led crisis respite services are available in the service mix.

- This would be a substantial departure from the Commission's intent, which recommended moving beyond the Piri Pono model - which is delivered in collaboration with the Waitemata District Health Board - to a model that is "independently led and governed by consumers"[52] as well as with a workforce "mainly of people with lived experience."[53]

Lack of clarity on how LLE-led organisations will be resourced as collaborators and partners

- Many of the partnership recommendations call for collaboration, co-production and co-design with LLE-organisations but do not discuss how this would best be facilitated.

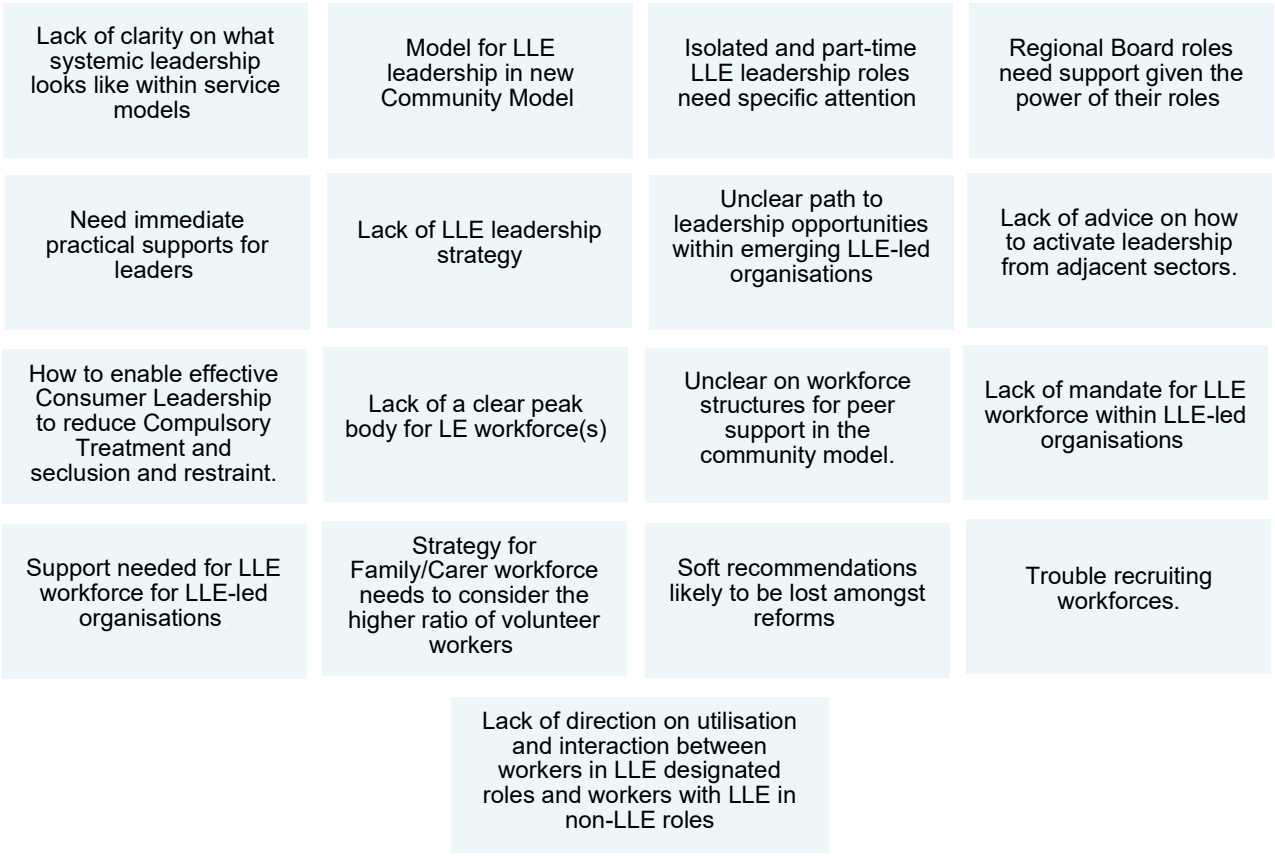
- Of particular note are recommendations involving collaboration with the Consumer Agency. There is a danger that this organisation will not be set up for success and be an empowered collaborator in these partnerships. It was recommended the Board be established as soon as possible, and the functions be initiated by end of 2022, and work to develop the LLE-led crisis respite service is already underway without collaboration with the Consumer Agency as was recommended.

[52] RCVMHS Final Report, Vol 1, Ch 9, p553.

[53] RCVMHS Final Report, Vol 1, Ch 9, p553.

LLE leadership and workforce gaps

The diagram below outlines the key gaps identified in recommendations about LLE Leadership and Workforce with each considered in detail below:



Lack of clarity on what systemic leadership looks like within service models.

- Need for systemic leadership, particularly in workforce and the development of the LE discipline, but lack of clarity on what this would look like so that it could be built into contracts, performance frameworks, outcome frameworks for services. Without it, services can articulate their own versions of leadership, e.g. tertiary services where a Clinical Advisory Group is chaired by a consumer being considered leadership.

- There is a big gap between peer workers, and system leadership (e.g. Rec 29) - there is an even bigger gap of information in this regard for family/carer workforces.

Model for LLE leadership in new Community Model

- Community model calls for significant uplift in peer worker roles - this is perhaps where biggest uplift will happen - but need to establish practical leadership structures for how to implement appropriate supports for these workforces, and drive cultural change within these models, especially given the emergent nature of these roles, i.e. there will be significant uplift in roles at the same time that key discipline establishing work is concurrently being done.

Isolated and part-time LLE leadership roles need specific attention

- There are key LLE leadership roles that are part-time in nature - e.g. Regional Board members, VCC Board members - given the part-time nature of these roles, and the

potential for isolation, specific attention needs to be made as to how to ensure these LLE leaders are supported and developed to be impactful at this key stage of reform.

Regional Board roles need support given the power of their roles

- Regional Boards are particularly isolated and will in future hold substantial power in the system.
- More support is needed for LLE leaders in these roles, as well as the Regional Board members more broadly, so that they are educated about the Commission's intentions for the role and the value of LLE leadership, workforce and partnership.

Need immediate practical supports for leaders

- It will take time to roll out the full suite of LLE leadership support programs (to be held by MH&W Commission and DH), when LLE leaders have already been recruited to key leadership roles. These will be key phases of the reform agenda where LLE leaders are likely to be making some of the most impactful decisions with the least support.

Lack of LLE leadership strategy

- More work needs to be done to establish what's needed for successful LLE leadership, and how DH and MH&W Commission will systematically enable this.
- This is also true for VCC, which has mandate to be an exemplar (along with MH&W Commission) but given the world-first nature of this needs advice on what this would look like in practice.

Unclear path to leadership opportunities within emerging LLE-led organisations

- As explored above, carer-led centres give mandate for services that are LLE-led, yet there is not mandate within key recommendations (Rec 5 - community model) for mandate for services to be run by LLE-led organisations.
- Given the above, LLE leaders could get training but no opportunities to lead LLE organisations that are sustainable and can attract ongoing contracts.

Lack of advice on how to activate leadership from adjacent sectors

- The Commission does not articulate how future leaders from adjacent sectors (refugee/migrant, Aboriginal, young people, LGBTQI+) could be identified, developed and brought into the system.

How to enable effective Consumer Leadership to reduce Compulsory Treatment and seclusion and restraint

- Further advice is needed for how systemic leadership will be most effective in reducing compulsory treatment and eliminating seclusion and restraint through the Mental Health Improvement Unit at Safer Care Victoria

Lack of a clear peak body for LE workforce(s) yet recommendations require collaboration with LE workforces in workforce design, support and capability building

- The Commission identified the lack of a body to represent LLE workforces in their final report; "the Productivity Commission recommended that the Commonwealth Government 'strengthen the peer workforce', including through the establishment of a professional

association to represent lived experience peer workforces"[54] yet did not recommend a Victorian representative body.

- There are several recommendations that involve working collaboratively with the LE workforces, yet there is no clarity around how, at an organisational or representational level, these workforces should be collaborated with. These recommendations are:
    - Int Rec 6: LE workforce development program should be "co-produced with people with lived experience and representatives of lived experience workforces".
    - Rec 57(3): DH to "design, implement and maintain a Workforce Strategy and Implementation Plan" and "encourage collaborative engagement and partnership with relevant workforce stakeholders".
    - Rec 58(4): enable the VCC, in collaboration with training providers, service providers and people with lived experience to coordinate learning and professional development activities across the whole workforce.
    - Rec 59(2): work with service providers, workers (including LE workers), unions, representative and professional bodies to implement a range of supports for the professional wellbeing of the workforce.
- In order to work collaboratively with LE workforce stakeholders, there needs to be clarity around who these workforce stakeholders are. As yet the LE workforces, given their emergent nature, do not have the same representative or peak bodies as other professions, and so there is a danger that true collaboration on these recommendations with the LE workforces cannot take place.

Unclear on workforce structures for peer support in the community model

- The Commission recommended peer support be integrated in a core function of the community model under "peer support, education and self-help", where all these three elements "will have elements of peer support, not just the peer support programs." Yet there is no detail as to how the education (i.e. Recovery Colleges in each of 22 AMH&WS) and self-help components will incorporate peer support and LLE leadership. In particular, the self-help component has very slim detail of what this would look like in practice.
- There is no roadmap for how to roll out these services, and as yet a risk that these will be rolled out without care taken to ensure they are led by empowered and supported LLE workforces. As mentioned in next steps, these services could be where DH plays system stewardship role to ensure fulfilment of the Commission's vision that LLE-led services are a prominent feature of the mental health system.

Lack of mandate for LLE workforce within LLE-led organisations

- As explored above, there is a lack of mandate for consumer-led organisations to deliver specific functions, this could side-line LLE-led organisations in service delivery and mean LLE workforces are largely contained within large NGOs and health providers.
- This could have a large impact on the development of the LLE workforces and disciplines. If the significant uplift in LLE workforces happens within the structures of larger NGOs and public health service, the discipline, structures, pathways and focus of LLE workforces will evolve in response to these non-LLE organisations and structures.

[54] RCVMHS Final Report, Vol 4, Ch 33, p541.

- This may mean that the original intent of LLE-led services, that is, to establish genuine alternative services and ways of working to clinical services, may be missed amongst the reforms. At its worst it may contribute to substantial co-option and peer drift of the LLE workforces.

Support needed for LLE workforce for LLE-led organisations

- As discussed above, the Commission calls for LLE workforce development to take into account the vision for a network of LLE-led organisations delivering services.
- This involves a significant uplift in the mechanisms and structures, drawing on expertise in Victoria and beyond, to ensure there are clear structures for how LLE-led organisations would structure their teams and workforce.
- There is yet no specific entity tasked with this role - ideally the Consumer Agency would do some of this work to support organisations, but as yet it does not exist. This is potentially a role that DH could take on in the meantime through business support, accelerator and/or grants programs to both support emergent LLE-led organisations as well as resource and fund real-world trialling of LLE workforce organisations and structures.
- Without this most workforce development will be geared towards training and supporting LLE workers to work within non-LLE organisations. Risk is that LLE workforce and work more broadly gravitates around responding to the clinical system rather than creating generative peer-led alternatives.

Strategy for Family/Carer workforce needs to consider the higher ratio of volunteer workers

- Overall, the workforce strategy needs to consider how to support people with LLE who are engaged in volunteer, or reimbursed volunteer or ad hoc paid roles (e.g. paid workshops or co-design processes)
- Particular attention needs to be paid to the family/carer workforce, of whom it is expected there will be a higher ratio of volunteer peer support workers, e.g. Carer-led centres will play a coordinating role for supporting volunteer Family/Carer peer worker delivered peer support programs.

Lack of direction on utilisation and interaction between workers in LLE designated roles and workers with LLE in non-LLE roles

- The Commission identified that a significant portion of the workforce (66% according to the workforce survey) have lived experience, yet only a small portion of these work in LLE roles.
- The Commission saw this as an opportunity to draw on, yet one with barriers (e.g. stigma). The Commission did not appear to provide any direction as to how to engage workers in non-LLE roles to support culture shift alongside LLE designated workers. More work needs to be done to understand how to work alongside workers with LLE in non-LLE roles to create allyship and draw on opportunities of undisclosed LLE already in the sector.

Trouble recruiting workforces

- Given the substantial uplift the recommendations represent, there needs to be concerted effort to recruit and train workforces, including bringing in expertise from outside Victoria, especially for leadership roles.

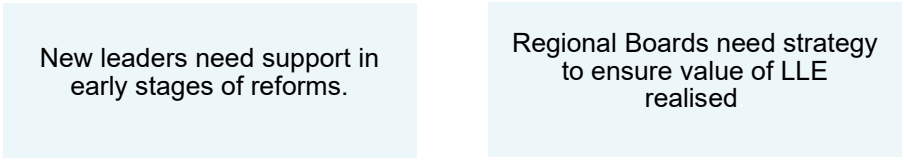
Soft recommendations likely to be lost amongst reforms

- Several soft recommendations for the LLE workforce, e.g. Rec 8, expand crisis outreach to include “support from a clinician and a non-clinical worker such as a peer worker.”

- Likelihood of these recommendations will not come to fruition given the other constraints on uplift in LLE delivered services.

LLE named leadership roles gaps

The diagram below outlines the key gaps identified in recommendations about LLE named leadership roles with each considered in detail below:



New leaders need support in early stages of reforms.

- As mentioned in previous section on leadership and workforce, new leaders need adequate supports, especially in early stages of the reform when decisions will be the most impactful.

Regional Boards need strategy to ensure value of LLE realised

- As also mentioned above the Regional Boards in particular will hold substantial power at full maturity but will be part-time roles and there is a lack of clarity around LE supports within these new commissioning bodies, work could be done to ensure these Regional Boards are strengthened from an LLE leadership perspective, which will have long-term flow on effects for oversight and commissioning in the system.

- This includes support networks, supervision, professional development, as well as support and training for non-LLE members of the Regional Boards, who may come from many different areas and be new to LLE value and approaches.

- As an example of the influence of Regional Boards, they are tasked with oversight of the mix of bed-based services in their region, and so could have a major impact on the proliferation or non-proliferation of peer-led crisis respites, peer-led drop-in centres and peer-led alternatives to hospital. These models may be new to many Regional Board members, so there is a risk that these models are not commissioned and do not become part of the service mix.

LLE partnership gaps

The diagram below outlines the key gaps identified in recommendations about LLE named leadership roles with each considered in detail below:

Lack of clarity on operational understanding of key partnership approaches	Service provider standards are soft standards that are open to interpretation	Lack of clear avenue for support and monitoring of partnership approaches
Lack of Consumer Agency, key to several partnerships	Lack of a clear peak body for LE workforce(s)	Need for systemic leadership model for partnership recommendations that involve LLE leaders

Lack of clarity on operational understanding of key partnership approaches

- Different partnership methods are recommended throughout the recommendations, yet definitional work needs to be undertaken to ensure that the sector understands what these approaches mean (e.g. the difference between co-design and co-production)
- Risk that without this system understanding, partnership approaches will be diluted and instead of partnership, consultation is the main way LLE is included.

Service provider standards are soft standards that are open to interpretation

- Given the range of operational experience and understanding across the sector of LLE partnership approaches, and clear models for systemic leadership and partnership, the intent of the service provider standards - for genuine partnership, collaboration, and to enable LLE-led services to emerge - could be diluted or lost.
- The Commission recommends DH and Regional boards support LLE-led providers to develop and thrive, with “this endeavour …supported by a new set of service standards"[55], yet as previously discussed, these service provider standards don’t appear strong enough to ensure this occurs.
- The Commission talks of “full maturity” without setting a clear timeframe for this and any key milestones.

Lack of clear avenue for support and monitoring of partnership approaches

- It appears there is no body specifically assigned to monitor and quality control partnership approaches to ensure they meet partnership standards.

[55] RCVMHS Final Report, Vol 3, Ch 18, p29.

- Alongside this, DH and Regional Boards at full maturity are designed to use service provider standards to ensure quality LLE partnerships, yet as discussed above, Regional Boards don't necessarily have the training and expertise to enforce these standards appropriately.

- Outside of recommendations, it is expected that services (as per service provider standards) engage in partnership with LLE. This will involve extra time and resourcing.

Lack of Consumer Agency, key to several partnerships

- Consumer Agency (Rec 29) is key to several recommendations as a collaborator and partner. The main recommendation did not have a clear timeline, but the implementation chapter (Ch 37) recommended that the Consumer Agency Board be established as soon as possible, with the functions of the agency initiated by the end of 2022.[56]

- Given the delay in establishing the Consumer Agency, there is a risk that recommendations designed to happen in collaboration with the Consumer Agency will begin without partnership with the Consumer Agency and therefore will be downgraded from collaborative partnerships to consultation or co-design. For example, Interim Recommendation 5 (Healing Place) which is already underway.

Lack of a clear peak body for LLE workforce(s) yet recommendations require collaboration with LE workforces in workforce design, support and capability building.

- As mentioned in the workforce section, there are several recommendations that involve working collaboratively with the LE workforces, yet there is no clarity around how, at an organisational or representational level, these workforces should be collaborated with.

Need for systemic leadership model for partnership recommendations that involve LLE leaders

- There are a number of recommendations that call for collaboration between organisations that will have LLE in key leadership positions, e.g. Rec 41 - MH&WC (with LLE Commissioners) to work with partners to design and deliver anti-stigma programs.

- Appears unclear how LLE leadership will be involved beyond leadership in these programs. This gap is similar to the lack of systemic leadership model as discussed in the workforce section.

[56] RCVMHS Final Report, Vol 5, Ch 37, p256.

Advice and steps for DH

The brief asked for advice and steps for the Department of Health and this section provides this based on the analysis of narrative and directions and gaps along with the sector knowledge of the authors.

It's important to note this report needs to be considered in conjunction with parallel projects including a literature review, scoping organisational readiness and environmental gap analysis, along with work that has been completed or still underway since the Royal Commission published its interim and final recommendations in 2021.

The advice and steps fall into following areas:

Address the narrative and directions

- The analysis in this report has identified the narrative and directions around lived experience leadership, partnership and workforce contained in the Royal Commission reports and recommendation.

- These will need to be included in the strategy DH are developing and ensuring all levels are addressed - from large scale endeavours like establishing the Consumer Agency to small yet profoundly significant reform like placing peer workers in crisis teams.

Address the gaps

- A key component of the advice is addressing the gaps identified above to ensure the strategy that is developed covers the sector requirements comprehensively and fulfils the intent of the Royal Commission.

- AOD and Harm Reduction LLE leadership, workforce and partnership stands out as a fundamental gap and needs to be addressed, including commonalities and differences with Mental Health around leadership, workforce and partnership.

Monitor recommendations across DH

- Further work should be undertaken internally at DH to ensure understanding of the many sub-recommendations or assertive commentary woven throughout the Royal Commission report. These recommendations will likely be held by policy teams outside the LE Branch. Given the dispersed nature of these recommendations, internal monitoring of their progress is needed to make sure they align with the Commission's intentions.

- For example, proper consideration in the set-up of the MH&W Innovation Body (Rec 64) as to how it will empower LLE in leadership, as partners for the Innovation Network, and how it will fund consumer-led initiatives from the MH&W Innovation Fund.

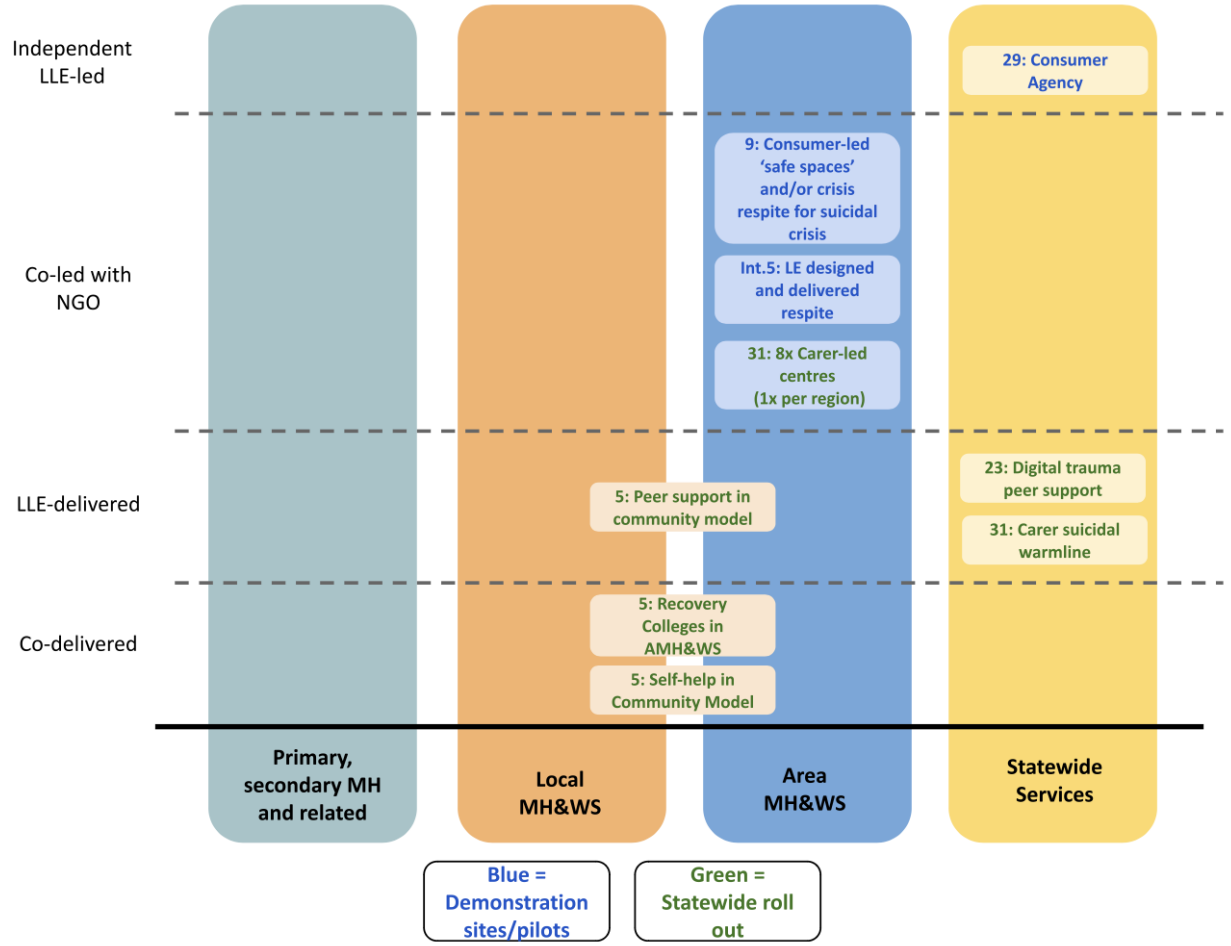
Strengthen LLE-led organisations and services

- LLE-Led organisations and services should be strengthened as these will be key components of the reform vision and ensure continuity and evolution of reform.

- There is a risk that recommendations will be interpreted in a way that diminishes the intent that LLE-led services and organisations are a "prominent feature" of a diverse service mix.

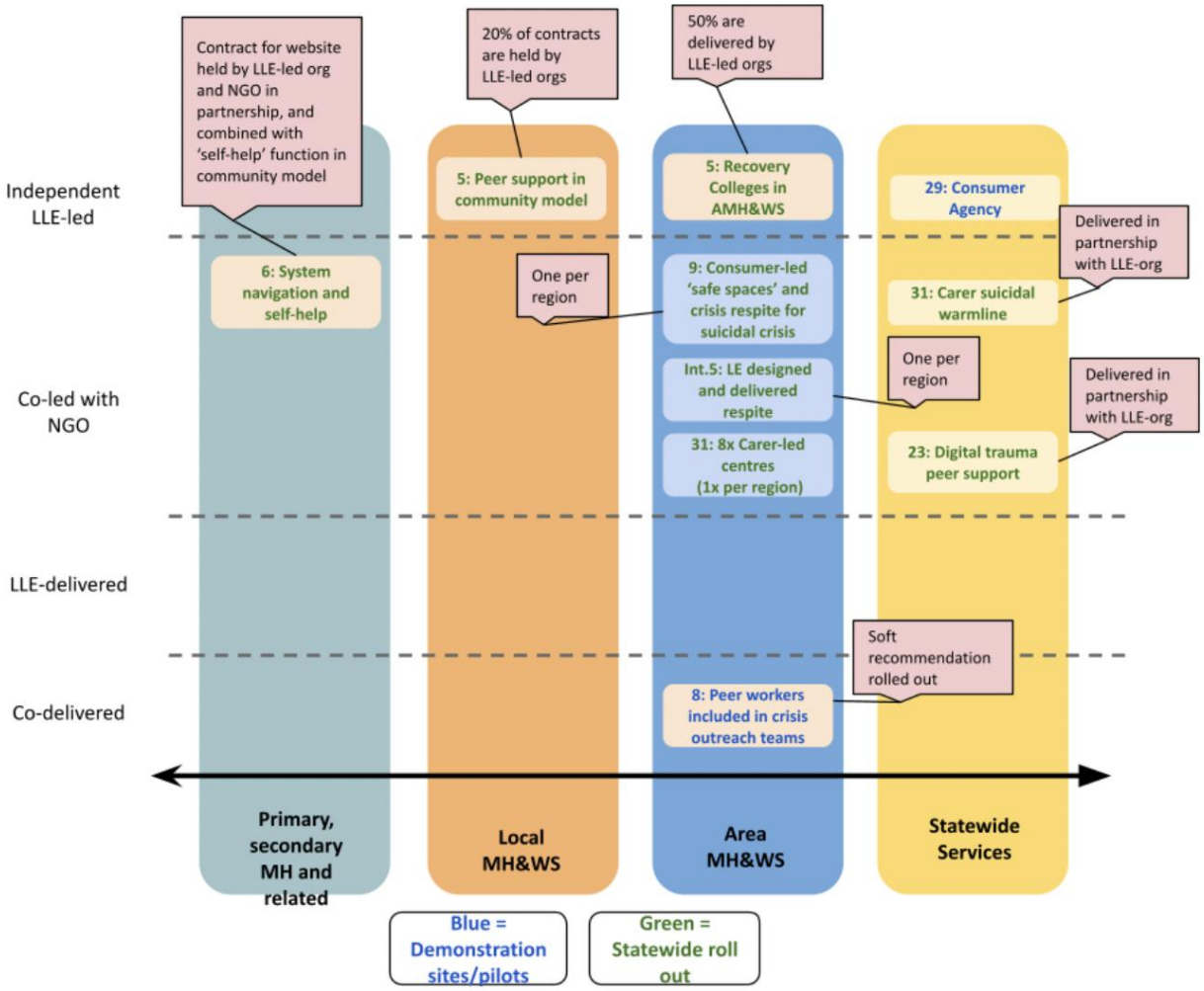
- There are many barriers to this, for example commissioning processes are dominated by health services that traditionally are more conservative, risk averse and sometimes have substantially less experience or understanding of LLE work.
- In this scenario, incentives need to be implemented to ensure the fulfilment of the Commission's vision, e.g. through strengthening of the service provider standards in relation to LLE-led organisational contracts.
- Alongside DH and the Consumer Agency, Regional Boards will also play a key role, educating, supporting and incentivising LLE-led organisations and services in commissioning processes.
- There is also a risk that interpreting and implementing the recommendations could fall short of the Commission's vision for LLE-led services and organisations are a genuine part of a diverse service mix.
- Figure 3 below shows the 'current state' of recommendations for LLE-led and delivered services, with Figure 4 showing how these could be elevated and strengthened so that they meet the intent of the Commission. For example:
    - **Peer support in the new community model** could, if it fulfilled the potential of the Commission, be a catalyst for LLE-led agencies to emerge and evolve to lead those services in partnership with the locals. Worst case scenario is it becomes a subset of clinical services, that while it might be co-designed, does not meet the Commission's intent of LLE-led services being a genuine part of a diverse service mix.
    - **Recovery Colleges** could be mandated to be developed and delivered by LLE-led organisations as a mechanism for enabling those organisations to exist and be part of a diverse service mix.
    - **The digital trauma peer support platform** could also be mandated to transition to an LLE-led organisation once they are established or at the least be co-led with a statewide service provider.
    - **LLE consultants and peer support workers** (usually employed by health services) could be employed centrally by a peer-led organisation, similar to Mind & Body from New Zealand during New Zealand reform period.
    - **Recommendation 6 to co-produce a website** to provide clear information on MH , services, as well as online self-help, could be contracted to peer-led organisation to deliver or co-deliver.
    - **The 'safe haven cafe' crisis response services** like the trauma support platform above could also be mandated to transition to an LLE-led organisation once they are established or at the least be co-led with a statewide service provider.

Figure 3 Current state of recommendations for LLE-led and delivered services



Note on Figure 3: where there is wiggle room in the governance arrangements that have been recommended for a service, the service has been placed in the lower option as this is likely to be the net result.

Figure 4 Strengthened state for recommendations for LLE-led and delivered services



Strengthen Regional Boards

- Regional Boards are tasked with significant roles and the LLE Leadership and Workforce in these should be strengthened as this will have a knock-on effect in the design, delivery and monitoring of everything in that region.

- For example, all other key bodies (VCC, MH&WC etc) have LLE mandated in substantive roles - commissioner, director, CEO. This is compared to Boards with part-time, single placement LLE on the Board and no executive management or workforce.

- Work needs to be done to keep LLE integrity as it decentralises to Regional Boards, this will include stipulating what LLE skills and expertise are needed for Regional Boards.

Map and monitor LLE workforces

- Undertake work to map workforce size and needs against ideal state for LLE leadership, workforce and partnership in the future.

- This should include breakdown of different roles across seniority (frontline workers, management, executive management, governance, advisory bodies, etc) and area (service delivery, regulation, research, etc)

- This should include work to map needs if all “soft recommendations” for the workforce are realised, e.g. Rec 8 - peer workers included in crisis outreach teams.

Map and monitor LLE partnerships

- DH needs to keep an up-to-date list of progress on these and assign these as an area of responsibility within the LLE Branch to monitor these projects across the division.
- DH could as part of this work keep an up-to-date website tracking progress on partnership projects so that the LLE community can keep track of which projects are underway, what the process is and how they can engage.
- Consideration could also be given to feasibility and usefulness of engaging services and funded agencies across the sector to provide up-to-date monitoring and report on service-led partnerships projects. There are factors to consider in implementation of an initiative like this, including how an initiative like this could support learning and growth relating to partnership processes.