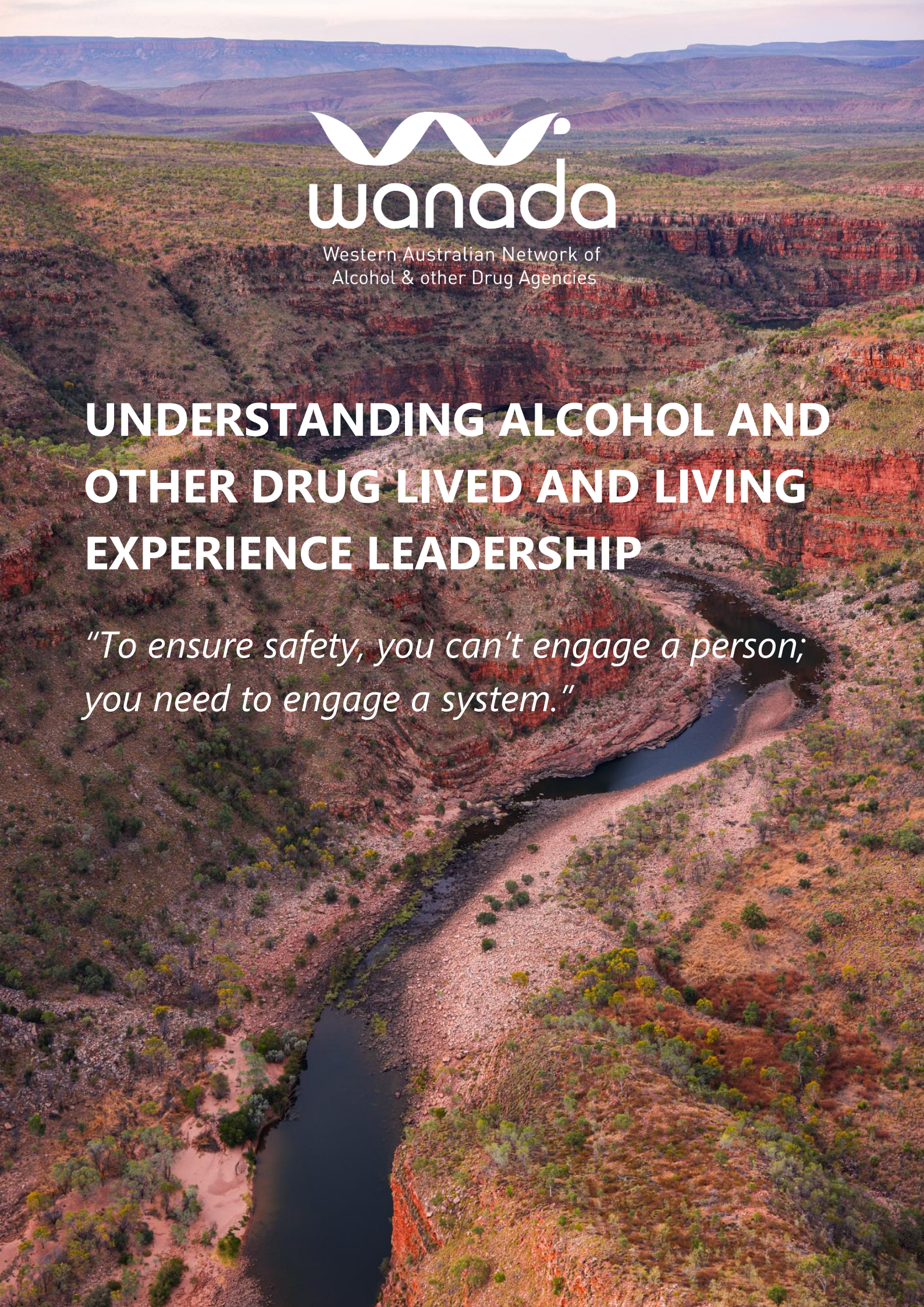


wanada

Western Australian Network of
Alcohol & other Drug Agencies

UNDERSTANDING ALCOHOL AND OTHER DRUG LIVED AND LIVING EXPERIENCE LEADERSHIP

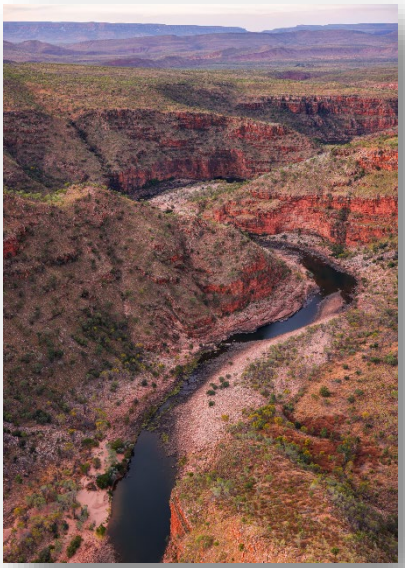
"To ensure safety, you can't engage a person; you need to engage a system."

We acknowledge the traditional custodians of the land on which we live and work, and recognise their strength in connection to the land, sea and community. We pay our respect to their elders past and present.

We acknowledge the widespread and intergenerational effects of colonisation. The policy and actions of dispossession established long-lasting barriers between peoples, land and their culture.

Furthermore, we acknowledge that this trauma has a systemic presence in Western Australian society, policy and the alcohol and other drug system. We acknowledge the need to address this issue by re-evaluating the systems in place which affect the cultural, social and economic matters of Aboriginal people.

WANADA is committed to advancing conciliation/reconciliation and fostering the valuable contributions that Aboriginal people make in the alcohol and other drug service sector, to deliver meaningful, lasting outcomes for Aboriginal people, families, and communities.



The aerial photograph of the river winding through the ranges and cliffs of the Kimberley in Western Australia, as featured on the cover, symbolises the journey of integrating lived and living experience (LLE) leadership within the alcohol and other drug sector. Like the river's adaptive and non-linear path, this journey requires flexibility, inclusivity, and a recognition of the diversity of experiences, challenges, and contributions within the sector.

This image also serves as a reminder of the connection to Country in Western Australia, which is central to many individuals and communities the sector serves and engages with. It acknowledges the enduring strength and wisdom drawn from these landscapes and the histories they hold.

We recognise the vital role of peers with lived and living experience impacted by alcohol and other drug use, whose unwavering leadership and advocacy have been instrumental in shaping the alcohol and other drug system across Australia. From the HIV crisis in the 1980s to today, peers have played, and continue to play, a pivotal role in establishing and sustaining services that save lives and advance the wellbeing of individuals, their loved ones, and their communities.

WANADA is proud to support these ongoing efforts and remains committed to elevating the voices of those most affected, drawing on their unique expertise and experiences.

WANADA would especially like to thank all the focus group participants from Western Australia who contributed to the development and refinement of this report, sharing their knowledge and invaluable insights with us.

Suggested citation:
WANADA. (2024). *Understanding alcohol and other drug lived and living experience leadership.*

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The development of "*Understanding Alcohol and other Drug Lived and Living Experience Leadership*" was supported by the Western Australian Mental Health Commission.

Executive Summary

Background

Incorporating "lived and living experience" (LLE) into the health system, particularly in mental health, has gained momentum in recent decades as a means to prioritise and advocate for the needs and perspectives of those with LLE. The *Understanding Alcohol and other Drug Lived and Living Experience Leadership Project* aimed to:

- better understand contemporary alcohol and other drug lived and living experience at the individual, expert and leadership levels
- understand how LLE is applied at the service, sector and systems levels
- provide an overview of appropriate engagement models
- identify key considerations for methods and processes to support ways of working with people with alcohol and other drug lived and living experience, experts and leaders.

In the alcohol and other drug sector, the history of people with LLE being heavily involved in the progression of the sector is extensive, with self-organised mutual support groups such as Alcoholics Anonymous operating as early as the 1930s. The stigmatisation of alcohol and other drug related harm, including dependence, outweighs the stigma attached to other health and social conditions and is reflected in the historical dominance of moral and/or medical interventions. In response, people with LLE have driven the creation of less stigmatising treatment alternatives from the field's inception.

LLE is very much woven into the fabric of the alcohol and other drug sector itself, with much of the WA sector evolving directly from, or alongside, LLE leadership. This distinction is important because it makes the alcohol and other drug sector unique, and therefore requires distinct consideration compared to other sectors. The distinction also extends to terminology. The LLE terminology, adopted more recently from mental health as a newer term, has sparked some contention in the alcohol and other drug sector. This terminology may not reflect the distinction that people who use alcohol and other drugs have been contributing to and driving the sector for a very long time.

Methods

The project employed a methodology comprising of:

- a comprehensive review of the academic and grey literature, including unpublished reports
- additional insights gathered through consultations with alcohol and other drug peak bodies nationally and informal interviews with sector representatives
- three focus groups conducted in Western Australia with consumers, peer workers, and sector leaders with LLE to further investigate key themes and gaps identified in the literature.

Limitations

While the findings of this report remain valid, they are somewhat skewed toward the experience of roles with LLE labels and those openly identifying as LLE. There is a lack of data on the Australian alcohol and other drug workforce, including the LLE workforce, and differences between the two. While limited, available data does reflect the extensive presence of LLE in the sector. However, most alcohol and other drug workers with LLE are not in designated LLE roles, and many choose not to disclose due to stigma and discrimination, a desire for privacy, or perceived relevance. The presence

of a large proportion of workers with LLE, albeit undisclosed and unacknowledged, may still influence practice in non-designated LLE roles in the alcohol and other drug sector. To better understand the size, characteristics, and dynamics of the LLE workforce - and differences between workers with and without LLE - further research mapping the WA alcohol and other drug workforce is necessary.

Findings

Alcohol and other Drug Workforce with LLE

Peer work is the most well-established and documented designated LLE role in the alcohol and other drug sector, employed across a broad spectrum of roles encompassing outreach and prevention, harm-reduction services, and treatment and crisis response. Designated LLE or LLE required roles are not limited to peer worker roles and can include alcohol and other drug project officers, representatives within advisory committees, participation on boards of directors and other governance bodies, consultants, educators and advocates, and peer researchers. While data on the roles of workers with LLE in non-designated LLE roles is largely unavailable, limited data and the observation that two thirds of the alcohol and other drug workforce report LLE suggest that types of roles and role specifications may be similarly distributed between workers with and without LE.

Workplace support is particularly necessary for LLE roles involving emotionally laborious tasks, with high risk of burnout considered a challenge for alcohol and other drug workers with LLE in other countries. Workplace support measures for the alcohol and other drug sector are described in the limited Australian and WA literature, but the extent to which these are accessible or utilised in practice, and which are perceived as most beneficial by workers with LLE, are missing from the literature. Limited data suggest Australian alcohol and other drug workers with LLE are not at higher risk of burnout than those without LLE, but this should be further tested. Given the lack of visibility and extent of LLE among alcohol and other drug workers, workplace support initiatives must be accessible by all workers or executed in a way to preserve anonymity and autonomy.

Key Challenges Faced by the Alcohol and other Drug LLE Designated Workforce

Stigma and Discrimination

Stigma towards alcohol and other drug use and its harmful impacts is arguably perpetuated in broader society through systemic issues such as the continued criminalisation of drug use and enforcement-driven policies, and this persists within the health system and the alcohol and other drug sector. Stigma and discrimination from (some) professionals without LLE towards workers who disclose alcohol and other drug LLE is present in the WA alcohol and other drug sector. This is further compounded for workers in designated LLE roles who are discriminated against due to their position being based on experience rather than formal qualifications, and a lack of professional understanding of the value of LLE work. Experiencing harassment, a lack of recognition compared to colleagues without LLE, patronising attitudes from professionals, and marginalisation within organisational internal hierarchies are reported in the literature and were echoed in the WA context. This contributes to a lack of safety and workplace trust, and feelings of being undervalued and disempowered. Lack of a supportive work environment and workplace trust are compounded by concerns around job security for LLE roles conditional on LLE status, which is incompatible with the non-linear nature of recovery.

Role Ambiguity and Inadequate Training

Role ambiguity is a major issue faced by the designated LLE workforce in the alcohol and other drug sector. A lack of clear role definitions for LLE positions reflects and perpetuates poor professional understanding of what LLE workforces do and how to work with them, leading to conflicting workplace expectations. This lack of clarity also contributes to feelings of frustration and being undervalued among workers. Many peer workers report that clinicians often do not understand their responsibilities, leading to tokenistic incorporation of LLE roles without adequate support or recognition of their contributions. A lack of adequate training and professional development further hinders the ability to establish a clear professional identity and foster respect and acceptance from non-designated LLE professionals, as well as navigate the often-emotional laborious duties such roles require.

Limited Career Advancement

Although the LLE label can provide access to roles without formal qualifications, it can be perceived as a barrier to career progression, leaving many LLE workers feeling stuck in entry-level roles with few leadership opportunities and unclear pathways for career growth. Poor understanding of LLE roles and the perception that they are less credible than traditional clinical roles may contribute to gatekeeping within the workforce. This highlights the importance of addressing root issues of stigma and discrimination in the broader workforce and identifying obstacles and opportunities for progression and leadership. Through consultation with key stakeholders, the report explored solutions for safe and meaningful career pathways, including addressing systemic barriers such as inadequate training, role ambiguity, and stigma. For individuals who may want to transition to careers beyond the alcohol and other drug sector, concerns remain that the LLE label, due to stigma, could limit these opportunities. As such, the need for choice in negotiating role titles that reflect role responsibilities rather than LLE status was proposed by focus group participants.

Barriers for Alcohol and other Drug LLE Leadership

Barriers specific to LLE leadership in the alcohol and other drug sector include cultural resistance to LLE leadership, challenges within the LLE workforce summarised earlier are an obstacle to a strong foundation for LLE leadership, limited data on the alcohol and other drug LLE workforce, lack of career progression pathways, and the more complex nature of enabling LLE leadership in this unique context. A broader sociocultural norm that favours formal education over experiential knowledge extends to the alcohol and other drug sector and broader health system, further hindering the acceptance of LLE in leadership roles. This is compounded by existing challenges within the LLE workforce, such as stigma and discrimination, role ambiguity, and inadequate training, which undermine understanding and legitimacy of designated LLE roles.

The scarcity of data on LLE workers in the alcohol and other drug sector hampers efforts to understand and develop this workforce, while also contributing to a lack of understanding and acceptance of LLE work and leadership by the broader workforce. Finally, increasing LLE leadership in the alcohol and other drug sector requires a nuanced and tailored approach. The practice of appointing one or few LLE representative/s to various committees may not effectively address the unique dynamics of this sector, where LLE is highly diverse, and trust and safety concerns are paramount due to the pervasive stigma surrounding alcohol and other drug use.

Enablers for Alcohol and other Drugs LLE Leadership

Models, methods and processes to address the noted challenges and barriers and effectively support ways of working with the alcohol and other drug LLE workforce and leadership, include labelling and terminology considerations, ensuring role clarity and professional development, facilitating supportive workplace cultures, creating leadership pathways, and systemic changes.

Exploring alternative terms for LLE that may have greater acceptability in the sector acknowledges the unique, long history of LLE in the alcohol and other drug sector. Providing individuals with the choice to adopt or decline LLE (or other related labels) in their role titles, as well as negotiating titles to reflect duties rather than LLE status, can be more empowering, and help mitigate concerns individuals in designated LLE roles have around stigma and negative impacts on career progression.

Establishing clear role definitions for LLE positions and ensuring access to adequate training, supervision and professional development can help legitimise LLE work and foster a supportive environment. Cultivating a systems and sector culture that values and respects LLE requires clearly demonstrated managerial support, supportive policy addressing stigma, and education for non-LLE staff about the contributions of LLE workers and how to work with them. Developing structured career pathways for LLE workers that recognise and elevate their contributions will enhance LLE leadership, thereby increasing visibility and influence within the sector.

Finally, embracing structural changes – such as embedding LLE roles across systems and sector and moving towards more democratic leadership models – can enhance LLE representation, acceptance and decision-making power, fostering LLE leadership and a more inclusive environment. Dynamic, fluid mechanisms bringing together both LLE and professional knowledge should be further explored with alcohol and other drug stakeholders.

Similarities and differences to the Mental Health LLE Workforce

Despite the more recent inclusion of LLE, similar challenges for the LLE workforce are described in the mental health LLE workforce literature, including stigma and discrimination, role ambiguity, inadequate training and support, and limited career advancement opportunities. Barriers specific to LLE leadership in the mental health sector, similar to those in the alcohol and other drug literature, include cultural resistance to LLE leadership, LLE workforce challenges described earlier that don't foster a strong foundation for LLE leadership, and lack of career progression pathways. Accordingly, proposed methods to mitigate these challenges and barriers also have crossover with the proposed methods in the alcohol and other drug literature.

Conclusion

Individuals with LLE have historically played a vital role in shaping the alcohol and other drug sector, making LLE a long-established concept within the field. This distinguishes the alcohol and other drug sector from other sectors, and therefore deliberate and increased integration of LLE also requires a distinct approach, which extends to considering alternative terminology accepted by the sector. Though two thirds of the alcohol and other drug workforce report LLE, a lack of data continues to hinder understanding and developing appropriate ways of working with workers with LLE and LLE leadership. However, given the large proportion of workers with LLE, it is likely that LLE workforce characteristics are similar to that of the general alcohol and other drug workforce, and that LLE may influence practice even in non-designated LLE roles.

Addressing the challenges faced by the LLE workforce and barriers to LLE leadership in the alcohol and other drug sector, and effectively, supporting ways of working with people, leaders and experts with alcohol and other drug LLE, requires a multifaceted approach, encompassing cultural change, role clarity and support, and systemic reform. This approach must also recognise the diverse experiences of LLE individuals and the need for safety. By leveraging the strengths of LLE expertise in equal combination with professional expertise, the alcohol and other drug sector can enhance the visibility and effectiveness of LLE leadership, improve service delivery and create a more inclusive, safe and equitable environment for all stakeholders.

Recommendations

The full Report presents the literature review and focus group outcomes with key findings (summarised version above) throughout the text leading readers from findings to detailed recommendations. The recommendations suggest ways of working with people, leaders and experts with alcohol and other drug LLE. A summary version of the recommendations is listed here for reference, with the list of findings and Actions attached in the Appendices.

Recommendation 1

Recognise that LLE engagement in the alcohol and other drug sector differs from other sectors.

Most WA alcohol and other drug services have emerged from LLE leadership and a large proportion of the workforce identify as having LLE (even when this is not a specific element of their role). In addition, the legal status of drugs and associated stigma faced by those who identify as having LLE, create distinctions with other sectors. There is also significant diversity of experiences, wants, and needs in relation to alcohol and other drug use and related harms.

Recommendation 2

Develop an ongoing strategy to identify the diverse contributions of the LLE workforce and leadership in the alcohol and other drug sector, including clear evidence of the benefits and impact and related challenges.

This work should inform tailored responses addressing workplace support, education, training, supervision, and professional development needs of LLE roles and leadership contributors. Strategies to enhance role confidence, competence, and legitimacy, alongside measures to ensure job and role engagement and security are critical.

Recommendation 3

Ensure training, management and governance structures and practices legitimise the LLE workforce and leadership roles across the alcohol and other drug workforce.

This is inclusive of contracting services as well as intersecting areas such as mainstream health, homelessness, and family and domestic violence services. Key priorities might include addressing role ambiguity, preventing and reducing stigma, and fostering respect and acceptance of LLE roles. Measures should reflect the fluidity between living and lived experience and be informed by the insights in this report. In partnership with intersecting service areas, a key starting point in reducing stigma and in understanding LLE leadership roles and building acceptability is to establish and maintain LLE leadership roles with cross sectors.

Recommendation 4

Identify and develop responses to challenges in embracing LLE roles, including leadership roles.

Key areas include responding to risk and evidence of discrimination, existing role ambiguity, and vulnerabilities linked to disclosure of activity that is contrary to current legislation and disclosure of behaviours that are considered to be among the most stigmatised in the world. Establishing and maintaining support and supervision mechanisms, preventing burnout, and ensuring credibility and acceptance of LLE and LLE leadership.

Recommendation 5

Ensure role security, remuneration and employee benefits for LLE roles that reflect role demands and avoid inequities with similar role levels.

Equitable job security, pay and other rewards are critical to legitimise and recognise the value of the LLE workforce and in particular, LLE leadership roles. This will require investment in considered and co-designed development of LLE leadership role descriptions and agreed understanding of role clarity, expectations and performance measures. It will also involve identification of implications of the LLE leadership role for career development and advancement. Equitable access to professional development, skill development and career pathways will need to be identified, developed and maintained.

Recommendation 6

Embed LLE systemically and safely, adopting a collective approach to LLE leadership.

This requires structural change to address inequities through the purposeful creation of senior leadership roles, increasing LLE representation in decision-making bodies, fostering shared leadership between LLE and professional/academic knowledge, and creating LLE roles at all system levels to enhance power and influence. Additional actions might involve implementing dynamic, issue-specific advisory groups with an LLE leadership "connector"/coordinator role, ensuring abundant and diverse representation to reflect the breadth of LLE experiences, and exploring alternate governance models such as financial or electoral systems.

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About this Report

Terminology

"Lived experience" (LE) in the alcohol and other drug context refers to the personal experience individuals have had with substance use, and participation in recovery, treatment and/or harm reduction services.[1] An individual with LE may have their own personal experience using alcohol and other drug, or may be a family member of someone who previously or currently uses alcohol and other drugs.[1]

The phrase "lived or living experience" (LLE) is sometimes used in the contemporary literature instead, acknowledging both past and present alcohol and other drug use[2]. Individuals with LLE may work in the alcohol and other drug sector, either in designated LLE roles (such as peer or LLE workers), where they purposely draw on their personal experience in their work[1], or oftentimes, in non-designated LLE roles, where they may not disclose their LLE[1]. Other related phrases include "people with lived experience" (PWLE)[3] and "representative staff" (staff in the alcohol and other drug workforce with LE)[4]; however, these are less common.

LLE was the preferred terminology among focus groups participants in this project and will be used throughout this report. The term LLE will refer to all individuals with current and/or past LE, in both designated and non-designated roles. The term LE will only be used when referencing studies that only measured *lived,* rather than *lived and living*, experience. **It is important to note that the term LE/LLE is not universally accepted in the alcohol and other drug sector in Western Australia.** This is discussed further in *Considerations around LLE terminology and labelling*.

Purpose of report

This report represents an enquiry into the evolving role of lived and living experience (LLE) leadership in the alcohol and other drug sector and its potential to contribute to system reform in Western Australia. It focuses on defining and contextualising LLE at individual, expert, and leadership levels. Informed by a comprehensive review of academic and grey literature, interjurisdictional insights, and engagements with key experts and stakeholders representing diversity across the alcohol and other drug and harm reduction spaces, the report aims to provide a nuanced understanding of how LLE leadership is applied across service, sector, and system levels.

The report explores appropriate engagement models and key considerations for methods specific to the Western Australian context to support ways of effectively working alongside LLE individuals, experts, and leaders. It also examines the similarities and differences of LLE in the alcohol and other drug and mental health sectors, while identifying opportunities to strengthen the integration of LLE expertise into inclusive and responsive systems.

Methods

A comprehensive review of academic literature was conducted, from an initial scoping exercise to specific search criteria using terms related to alcohol and other drug lived experience, such as peer, peer worker, co-design, consumer participation, etc, and then layering terms related to lived experience leadership (e.g., leadership, advocacy, educator, advisor, etc). Filters were applied to refine search results and exclude irrelevant material, focusing on alcohol and other drug contexts.

Key terms from a recently published WA government report "Lived Experience Workforce Framework"[42] were also incorporated, as were other areas searched using lived experience where the term applies (e.g., mental health, cancer or cystic fibrosis). A detailed methodology of the literature review is available on request.

A grey literature review (including unpublished reports) was then conducted. This included past alcohol and other drug conferences, online databases, and websites of peak alcohol and other drug bodies and consumer representative groups in Australia. A call out for relevant work was sent out to the sector nationally through peak bodies and other relevant organisations, with all received documents included in the review. Conversations with representatives of alcohol and other drug peak bodies in Tasmania and Victoria were also conducted and included.

Three stakeholder focus groups were then held in WA with consumers, peer workers, and alcohol and other drug sector leaders with LLE. These focus groups concentrated on key themes and gaps identified from the literature review and key issues identified by participants during the sessions.

- Peer participants were recruited through an expression of interest via the WANADA newsletter and direct engagement with alcohol and other drug services.
- Leader participants were recruited through WANADA member services and key stakeholders.
- Consumer participants were recruited through targeted engagement with an alcohol and other drug consumer advocacy group whose consumers are typically marginalised.

Each focus group lasted 2-3 hours and was conducted in person, with one regional participant attending online. The peer and leader focus groups each had 10 participants from harm reduction, treatment, community prevention, transitional care and advocacy services across Perth Metro, Mid-West and Wheatbelt regions. Each of these sessions were facilitated by a WANADA project member. The consumer focus group had 6 participants and was facilitated by the group's regular facilitator to ensure participant safety. This facilitator had a thorough understanding of the project, and the project staff were also present to contribute to facilitation. Notes from the sessions were recorded by two project members, cross-checked afterwards for accuracy, and compiled into a final version, which was also cross-checked. With participant consent, peer and leader focus groups were also audio recorded.

Background

The stigma of alcohol and other drug related harm, particularly regarding illicit substances, including dependence outweighs that surrounding other health and social conditions[5,6], and serves as a long-standing formidable barrier in workplaces, health systems and the global community[5]. It has been argued that systemic factors, such as the ongoing criminalisation of drug use and enforcement-driven policy over harm reduction policy, ensure continuation of the existing stigma surrounding drug use and those who use drugs[7]. A historical dominance of moral and/or medical interventions for people using alcohol and other drugs gave rise to self-organised mutual support groups, which offered a less stigmatising treatment alternative[8].

Alcoholics Anonymous is the most well-recognised example, operating since 1937[1]. People with LLE have had a long history of working in the alcohol and other drug treatment and support space[1,2,5]. Up until the middle of the 20th century, self-organised mutual support groups were the dominant

form of care available for people in the United States (US)[4]. Increased government spending did see the addition of alternative treatment and medical service providers[4]. However, the work and advocacy of people with LLE, alongside public health campaigners, continued to drive progress. In Australia and Aotearoa New Zealand (NZ), workers with LLE drove the creation of some of the first recovery-focussed treatment centres in the 1970s, and other treatment and harm reduction approaches in the 1980s[1,8].

Through the 1980s and 1990s, people with LLE played a crucial role in Australia's response to the HIV/AIDs crisis, involving harm reduction public health strategies[1]. Though attracting some contention at the time, Australia's response is now considered one of the best in the world. Notably, while incorporating "lived experience" knowledge and voice into services, sectors and systems is a relatively new area of focus in health and behavioural sciences[2], this concept has been present in alcohol and other drug treatment and service provision since the birth of the field. This contribution of workers with LLE to the alcohol and other drug field is increasingly recognised[1,2,5]. It is noted that much of the WA alcohol and other drug sector evolved from or with LLE leadership. Many of those in formal health services for alcohol and other drug related harm came with LLE as part of their expertise, and this was echoed in the leader focus group[9].

Over the last several decades, professionalisation of alcohol and other drug services has occurred. However, stigmatisation of alcohol and other drug use, related harm and dependence in the broader community, health systems and within services still exists.[5] Among other adverse outcomes, this can result in poor service provision, reluctance to seek help and more limited engagement with assistive services.[10,11] Client-clinician distrust due to past stigmatising experiences remains a barrier for some service users.[4] In this context, workers with LLE can be perceived as safe and trustworthy staff members,[4] and often as more understanding, due to shared experience.[11] They can also contribute to more welcoming, engaging and effective service provision.[12,13] Therefore, services which use LLE staff are advantaged by reducing the gap between service users and practitioners.[2] Indeed, the relatively new trend of purposefully increasing LLE expertise in service delivery, research, policy and evaluation is partly a response to the failure of services reaching those who need it most.[7] It is well recognised that LLE workforces can draw on their own experience and identity to empathise with patients and their challenges, and can sometimes identify treatment or service options more aligned with the patients' health and concerns.[4] It has been argued that LLE workforces offer a unique position in their ability to role model and instil hope.[2,14,15]

In WA, WANADA and the Alcohol and Other Drug Consumer & Community Coalition (AODCCC) 2022 peer workforce and consumer survey (n=124, 75 were consumers) found that 67% of service users believed it important that alcohol and other drug workers had relevant personal experience.[12] 94% of consumers felt that the employment of workers with LLE within services instilled a sense of hope, increased their comfort and ability to build rapport, and increased their confidence in the support provided.[12] . Further, the potential of staff with LLE to influence staff without relevant personal experience on matters such as stigma, patient empowerment and improved services is noted in the literature.[4] There is some evidence that incorporating staff with LLE into behavioural health services can generate increased client-service provider trust, increased client-centred outlooks for service providers and enhanced quality of delivered services.[16] Improved clinical decision making, health outcomes and service development can all be aided by consumer participation, and as such the embedment of workers with LLE into service delivery models in

Australia is increasing[1]. Information about the specific critical characteristics of effective LLE work and what risks might need to be addressed is more limited.

Alcohol and other Drug Workforce with LLE

Prevalence

Internationally there is relatively little information known about the alcohol and other drug workforce and characteristics, and the similarities and differences between categories of workers.[17] Australia does not currently have a national data repository recording the size of the alcohol and other drug workforce.[1] To date, most published research on alcohol and other drug workers with LLE has been concentrated on designated LLE roles, predominantly peer workers, with limited data focussed on workers with LLE who are not in designated peer roles.[1] In the US, 30% of the "addiction" treatment workforce are *estimated* to have LE.[5] In NZ, the 2008 National Telephone Survey of the Addiction Treatment Workforce found that 32% of participants reported to be in recovery.[18]

To date and to our knowledge, in Australia there are only two published papers on the prevalence and characteristics of workers with LE.[5] At the services level, this was explored by researchers in 2020 with an Australian survey of 986 alcohol and other drug workers in direct client service roles.[1] Findings indicated that the boundary between the peer and professional workforce may be less distinct than expected, with 67.2% of respondents reporting LE.[1] Of this group, 34.5% reported personal LLE and 32.8% reported family/other LE.[1] Notably, despite over two thirds of participants reporting LE, only 2.4% were in designated peer roles.[1] The second paper, based on a 2020 survey of one third of alcohol and other drug workers in NSW nongovernment organisations (NGOs), found 42.5% of participants reported LE.[5] Interestingly, in the aforementioned national survey, NGO workers had higher levels of alcohol and other drug LE.[17]

High figures are also reported in the current Western Australian grey literature, with WANADA and AODCCC's 2022 survey of the alcohol and other drug workforce (n=135) finding 62% of participants willing to identify as having LE.[12] Of this 62%, 18% were in designated LE roles .[12] A 2023 alcohol and other drug Tasmanian workforce survey conducted by the Alcohol, Tobacco and other Drugs Council Tasmania (ATDC) revealed the same prevalence of workers with LE (around two thirds of the workforce).[19] The Victorian Alcohol and Drug Association (VAADA) found a higher prevalence of 85% in the 2023 workforce development survey.[20] Since it appears more workers have LE than previously thought, LE perspectives largely represent those of the broader workforce.[5] This suggests LE, albeit undisclosed and unacknowledged, is drawn upon and influences practice in non-designated roles.[11] Indeed, in the 2022 WANADA and AODCCC workforce survey, 86% of the workforce with relevant personal experience agreed that their personal knowledge, awareness and experience was assistive to their role.[12] As a point of interest, 80% of consumers surveyed were also already working or interested in working in the sector.[12]

Key finding 1
There is a long history of LLE in the alcohol and other drug workforce. The literature on the Australian alcohol and other drug workforce and LLE is limited. Approximately two thirds of the WA alcohol and other drug workforce report having LE. The boundary between the peer and professional workforce may be less distinct than expected. This suggests LLE, albeit undisclosed and unacknowledged, could influence practice in non-designated LLE roles in the alcohol and other drug sector.

Disclosure

In both of the aforementioned 2020 Australian surveys, around one third of alcohol and other drug workers who reported LE had not disclosed this in their workplace.[1,5] In the national study, non-disclosure was significantly more likely among individuals with family or other types of LE compared to individuals with personal LE.[1] However, for those who had not disclosed, citing stigma/judgement or confidentiality as reasons against disclosure, was significantly more likely among individuals with LE compared to those with family/other experience.[1] In the WA specific context, for all workers who reported LE, around one quarter said that their employer was unaware of their LE.[12]

Although more workers in the alcohol and other drug workforce reported LE than previously thought, concerns around stigma and/or a desire for confidentiality are cited by staff as barriers to disclosure.[1] This finding was also echoed in the focus groups conducted for this project in the WA setting among peer workers and some sector leaders with LE. One participant in the sector leaders focus group stated,

"After people have disclosed, you watch other people tip toe around them…[due to the thinking that]…relapse is inevitable".

This participant described observing how disclosure changes relationships between people in the office, with professional/client boundaries being applied to relationships with staff following their disclosure. Other participants noted that as well as the "classic" stigma of medical professionals against people who use alcohol and other drug, they had observed internal stigma within alcohol and other drug services from clinicians against workers who had disclosed LE.

Disclosure is also influenced by the perceived relevance of personal alcohol and other drug experience to current work roles, which may differ among workers.[1] This was also echoed among all three stakeholder focus groups held for this project, with concerns around the timeframe by which LLE may still be considered relevant to a current role. One participant in the leaders focus group observed,

"At what point does my LE become irrelevant…my LE 30 years ago cannot represent contemporary LLE".

Participants in the leaders focus group also discussed the relevance of disclosing LE when this was but one factor shaping their career and leadership approach.

"Sure, LE can come into it, but it's not your only skill as a leader".

While personal autonomy around disclosure is essential, from a research and workforce development perspective non-disclosure does act as a barrier in understanding the extent of LLE and its role in the sector.

Key finding 2
Many alcohol and other drug workers do not disclose their LLE, due to concerns around stigma & discrimination, and/or because of lack of perceived relevance to their current role.

Key finding 3
Individuals with personal LE are more likely than individuals with family/other LE to cite stigma and judgement or confidentiality as reasons against disclosure.

Characteristics

Official demographic data are not available on the alcohol and other drug workforce (or the workforce in designated LLE roles), however, the characteristics in the aforementioned 2020 Australian survey of workers in direct client service roles echoed previous alcohol and other drug workforce surveys.[1] This survey found that most alcohol and other drug workers were women (70.9%), 34< years old (77.4%), employed in the NGO sector (58%) and had worked 6< years in the sector.[1] In the WA context, the WANADA and AODCCC 2022 workforce survey found that most workers were women (57%), 45< years old (50%) and held a TAFE qualification or higher (70%).[12] 11% of the workforce reported Aboriginality, 9% reported culturally and linguistically diverse (CaLD) backgrounds, and 8% were LGBTQI+.[12] Given that two thirds of the workforce report LE,[1,12] it is also possible, but not verifiable from these reports, that these characteristics may also be representative of the workforce with LLE.

In the national survey, workers with LE (in designated and non-designated LE roles) possessed fewer formal qualifications[1,5] and were significantly more likely to work in the NGO sector.[1] Workers with family or other LE were significantly more likely than workers with LE to have tertiary qualifications, while workers with personal LE were significantly more likely to work in the NGO sector than those with family or other LE.[1] Demographic characteristics data in WA were not identified for workers with LE specifically, but the aforementioned survey of NSW alcohol and other drug NGO workers found that while most of the workforce were female (67%), workers with LE were 54% female, implying a more equal gender distribution for workers with LE at NGOs.[5] This survey also found that 75% of workers with LE identified as heterosexual (compared to 91% of workers without LE), suggesting workers with LE at NGOs may be more sexuality diverse.[5] These data were specific to the NSW NGO context and were argued as generally representative of the national NGO workforce,[5] however we cannot generalise to the broader alcohol and other drug workforce.

Further research mapping the Australian alcohol and other drug workforce is required to better understand size and characteristics, and the differences between workers with and without LLE.[1] Mapping the LLE workforce size and characteristics specifically has potential to decrease the stigma surrounding alcohol or other drug use and related harm and to acknowledge the value of LLE in the workforce.[1]

Key finding 4
There is a general lack of data on alcohol and other drug workforce characteristics, including the alcohol and other drug LE workforce. (Recommendation 1 *and suggested action 1*).

Roles

Designated LLE roles: peer workers

Although most workers with LE in the alcohol and other drug sector are not employed in designated LE roles,[1,5] there is much more literature on the designated peer-workforce than other roles using LE.[1] Peer work is the most well-established and documented LE role in the sector, employed across a broad spectrum of roles encompassing outreach and prevention, harm-reduction services, and treatment and crisis response.[1,3,14,16,21] Peer work, inclusive of paid and voluntary roles, usually takes place in three types of service settings or models; organically formed mutual support groups, peer-run services and recovery organisations, or clinical or rehabilitation settings where peers work as providers.[22] Peer work may also take place within hospitals,[14,23] and criminal justice settings such as court, jails or probation centres.[24,25] Peer workers may be described as "peer workers", "peer support workers", "peer specialists", "peer mentors", "peer outreach worker",[14] "peer councillor",[23] "recovery coaches",[14,26] "peer educator"[7].

Peer workers are in a unique position to provide support to service users in a variety of settings, drawing on their own experience and identity to empathise with patients and their challenges.[1,3,4,23] Building relationships with peers has been proposed as a means of community engagement and participating in fulfilling activities, which fosters development of a positive self-identity and protection against relapse.[18] Therefore, emerging hypotheses argue the mutually generative relationship between personal and social recovery capital.[18] That is, as an individual in a community whose capacity for recovery grows, so does the community's capacity for recovery. This goes both ways; when a community's capacity for recovery grows, so does the capacity for recovery of each individual member.

Literature documents the positive outcomes of peer intervention including statistically significant improvements in service users harmful substance use (reduction of harms),[13,14,27] recovery outcomes,[14] relapse rates,[13] and improved relationships with social support systems.[13, 28] The literature supports the enhanced reach and effectiveness of harm reduction interventions when people with LLE are involved.[3] Decreased drug-related harms are evidenced,[3,27] including for groups who might not usually engage with traditional public health programs.[3] Building trust and rapport between clients and services, increasing client confidence in the services and support provided,[12,13] and increased treatment retention,[12,13,27] are other key functions of the peer worker role.

Duties and responsibilities vary greatly, but can include one-on one counselling/support,[29,30,31,32] home visits, facilitating or attending mutual aid groups with clients, attending appointments with clients,[29,30,32] providing education, referrals for housing, jobs and other needs[31,32,33] engaging in harm reduction interventions (e.g. distributing sterile needles and syringes, providing safer drug using/harm reduction education, training people who use drugs to respond to overdose and administer naloxone, working within Drug-Checking Services),[29,31,34] case management,[29,31] financial counselling,[29,32] providing system navigation,[35] administrative tasks/documentation,[32] community

outreach,[31,32] client advocacy within services,[2] advisory committee participation, and research assistance.[29]

In WA, the WANADA and AODCCC 2022 sector leader survey found that 50% of services employ peer workers,[12] however, quantitative data on the different types and distribution of peer worker roles across the sector in Australia and WA are missing from the literature. Both individual and family LLE are represented in peer worker roles in the WA context.

Key finding 5
Majority of alcohol and other drug workers with LLE are not in designated LLE roles.

Key finding 6
Peer work is the most well-established and documented designated LLE role in the alcohol and other drug sector, employed across a broad spectrum of roles encompassing outreach and prevention, harm-reduction services, and treatment and crisis response.

Key finding 7
Positive outcomes of peer intervention include reduced alcohol and other drug related harms for service users, improvements in recovery outcomes and relapse rates, increased reach of harm reduction programs, increased treatment retention, and increased client confidence and trust in services and support.

Designated LLE roles: non-peer workers

Despite the abundance of literature on peer worker roles, the 2020 survey of alcohol and other drug workers in direct client roles reported that only 2.4% of workers were in peer roles, despite 67.2% reporting LE.[1] Looking beyond peer work at a broader range of designated LLE roles, the aforementioned survey of NSW NGO workers found that 18.4% of staff with LE worked in a designated LE role.[5] A review of the training of LE workforces found that beyond peer worker roles, other designated LE workforce roles include consultants, educators and advocates.[2] In the US, looking broadly at behavioural health treatment services, LE knowledge is being widely used, contributing to service delivery, policy development, the creation of new models of care and involvement in interview panels.[16]

Workers with LLE may serve as representatives within advisory committees, boards of directors and other governance bodies.[16] The practice of involving people with LLE in qualitative alcohol and other drug research as peer researchers is also growing.[36] This suggests there is movement beyond the tokenistic foundations of incorporating LLE knowledge in the sector into an expectation of providing more meaningful modes of LE contribution.[16] NZ has recently established advisory roles specifically for people with family LLE to engage with state and NGO run mental health and "addiction services".[8] Though there have been few workforce development initiatives so far to recruit and retain workers in these roles,[8] the move indicates the emerging recognition of family members and their knowledge as an integral part of the "natural workforce".[37]

In WA, 29% of the workers reporting LE in the 2022 WANADA and AODCCC workforce survey were in roles where personal LE is a role requirement, however most workers with LE were not in

designated LE roles.[12] The survey found that beyond peer support workers roles, those in designated/required LE roles also worked as duty workers and alcohol and other drug project officers.[12] In the same survey, 43% of workers with LE reported contributing to service-level policy, and 27% had contributed to sector-level policy.[12] Not all of these workers were in designated LE roles, but noted their LE likely affected their input.[12]

Key finding 8
Designated LLE or LE required roles are not limited to peer worker roles and can include alcohol and other drug project officers, representatives within advisory committees, boards of directors and other governance bodies, consultants, educators and advocates, and peer researchers (Recommendation 1, *and suggested action 1*).

Undesignated roles using LLE

There is a lack of literature exploring workers who have LLE but who work in non-LLE designated roles, however the 2020 Australian survey of NSW NGO workers found the types of roles, contract type, work locations and workload hours between workers with and without LE were similar.[5] In this study, 41% of all workers (LE and non-LE) were in administration, 76% were in client facing roles, and 30% were in management positions.[5] This survey was considered representative and can be generalised to the national alcohol and other drug NGO workforce[5] but cannot be generalised to the broader alcohol and other drug workforce. In the Australian survey of workers in direct client service roles, 25.2% were in counselling, 14.6% in intake assessment and 10.6% in case management,[1] however we cannot generalise with confidence to the LLE workforce as this was not referenced in the report.[1] The roles of workers with LLE in non-designated LE roles was not specifically reported on in the 2022 WANADA and AODCCC WA workforce survey, but most common roles in the broader workforce were support workers (24%), counsellors (20%), counsellor/educator (12%), clinical coordinator (12%) and managers (9%).[12] Given that two thirds of the workforce reported LE, it is possible a somewhat similar distribution of roles would be reflected in workers with LE in non-designated LE roles, but research is needed to explore this. As noted earlier, in the same survey, 43% of workers with LE reported contributing to service-level policy, and 27% had contributed to sector-level policy.[12] Not all of these workers were in designated LE roles, but noted that their LE likely affected their input.[12]

While there is a consensus within the WA alcohol and other drug sector that people with LE work in varying roles, including in a leadership capacity (9, leaders focus group), quantitative data on role types and distribution of roles pertaining specifically to workers with LLE are missing from the literature. In the Australian and WA context, research is needed to map role type and distribution within the alcohol and other drug workforce, and particularly with differentiation between workers with and without LLE (in designated and non-designated LLE roles). Such work would provide a clearer picture of how LLE is distributed across roles at the services, sector and systems levels.

Key finding 9
Limited data and the observation that two thirds of the alcohol and other drug workforce report LE suggest that types of roles and role specifications are similarly distributed between workers with and without LE, but further research in the Australian and WA context is needed to explore this *(*Recommendation 1, *suggested action 1)*.

Existing Workplace Support

Workplace support initiatives for workers with LE are necessary to promote well-being, improve recruitment and retention, and ensure best practice.[1] Given most workers with LE are not in peer or designated LE roles, and a significant proportion choose not to disclose their LE, initiatives must be accessible by all workers or executed in a way to preserve anonymity and autonomy.[1] However, it is also worth noting that supportive accommodations necessary for peer workers are no greater than those required by other staff.[24] From the little data available, it appears Australian workers with LE in direct client service roles have similar levels of work engagement than those without LE and there was no evidence of higher risk of burnout.[1] There were also no significant differences between workers with personal LE and family/other LE.[1] Given the little Australian data available and risk of burnout being described as a challenge for alcohol and other drug LE workers in other countries due to stigma and discrimination, role ambiguity and intensive emotional labour,[3] mapping of existing workplace support and risk of burnout for alcohol and other drug LE workers in the WA setting should be further tested.

Key finding 10
Given the limited visibility and extent of LE among alcohol and other drug workers, workplace support initiatives for workers with LE must be accessible by all workers or executed in a way to preserve anonymity and autonomy.

Key finding 11
Limited data suggest Australian alcohol and other drug workers with LE are not at higher risk of burnout than those without LE, however high risk of burnout is considered a challenge for alcohol and other drug workers with LE in other countries *(*Recommendation 2*, suggested action 5)*.

In the aforementioned survey of AUS alcohol and other drug workers in direct client service roles, informal support among peers/colleagues, frequent debriefs with a colleague, and counselling sessions were perceived by workers with LE to be the most beneficial workplace support initiatives.[1] Informal support among peers/colleagues and frequent debriefs with a colleague were reportedly accessed by 86.3% and 68.3% of workers with LE respectively.[1] Counselling was only personally accessible for 49.5% of workers with LE.[1] Support groups, wellness/"chillout" rooms and external programs were perceived as beneficial support measures, but were the least accessible, with 29.5%, 19.3% and 32.6% of workers with LE reporting access respectively.[1] Particularly, informal support groups and external programs were more difficult to access for workers with family or other LE as opposed to personal LE.[1]

Comparable parallel data in the WA context are not available but participants in the 2022 WANADA and AODCCC leaders survey reported access to supervision, training and mentoring opportunities (standard for all workers and further as required), dedicated peer programs, and partnering peer workers with other staff for extended learning opportunities and mutual support as workplace support practices in place for alcohol and other drug workers with LE.[12] Further data on the workplace support available for workers with LLE in the WA context, the extent to which this is accessible/accessed in practice, and that which is perceived to be the most beneficial by workers with LLE is missing from the literature.

Key finding 12
Limited data in the WA context suggests workplace support measures are in place, but the extent to which this is accessible/accessed in practice, and that which is perceived as the most beneficial by workers with LLE are missing from the literature (Recommendation 2, *suggested action 5*).

Key Challenges Experienced by the LLE Workforce

Stigma and discrimination

It has been argued that systemic factors, such as the ongoing criminalisation of drug use and enforcement-driven policy over harm reduction policy, ensure continuation of the existing stigma surrounding drug use and those who use drugs.[7] Stigma presents a significant challenge for alcohol and other drug workers with LLE, impacting their professional environment and compensation.[1,3,5,11,24,38] Some research indicates that stigma associated with the alcohol and other drug sector may contribute to lower pay compared to other fields of behavioural health care.[1] Participants in the leaders focus group emphasised the importance of eliminating stigma to ensure safety and enable meaningful engagement with LLE.

Workers with LE frequently report higher instances of workplace discrimination and harassment compared to their colleagues without LE.[3,5,38] This disparity is compounded by the observed inequities in pay and benefits. In the Canadian harm reduction setting, for example, stigma and workplace discrimination, including power imbalances and inadequate compensation, persistently affect peer workers.[3] Workers in these settings face a high risk of burnout due to continuous exposure to stigma, discrimination, and disparities in power and pay between staff with and without LE.[3] Peer workers identified stigma as a primary issue affecting their work, noting that they are frequently undervalued compared to their academically trained counterparts within their organisations, and spoken to patronisingly.[3] The emotional labour undertaken in LE roles is often unrecognised and uncompensated, further highlighting systemic inequities. A global systematic review of peer support (in homelessness and problem substance use services) emphasised these observed inequities in pay, support services and benefits, finding peer workers frequently went without the standard benefits offered to workers in non-peer roles, including health benefits, counselling access and personal leave.[28]

Further, the cultural norm of valuing formal education over other forms of knowledge, such as LE expertise, contribute to a lack of recognition and acceptance of workers in LE roles.[28,39] A global review of LLE workforce training found that, consistent with previous research, negative attitudes of clinicians towards LLE work and the resulting workplace culture was a major issue faced by LLE workers.[38] Another systemic review found that workers in designated LE roles in alcohol and other drug services report marginalisation from other professionals.[11] In the U.S., peer workers reported increased stigma when interacting with staff without LE in clinical settings, compared to within peer-run organisations.[24] This systemic stigma is reflected at the organisational level, where exclusionary attitudes and policies contribute to a challenging work environment.[7] The peak consumer body in VIC, the Association of Participating Service Users (APSU), located within the Self Help Addiction Resource Centre (SHARC), observe that providers may underestimate the potential for effective consumer participation because of stereotypes around drug use and lifestyle.[40] APSU also note the

possibility that providers may perceive consumer participation to be a threat to existing power structures.[40]

Within the Australian context, a third of LE workers within the ATDC (Tasmania) 2023 alcohol and other drug workforce survey reported concerns about stigma as a barrier to their roles.[19] One Australian paper found that workers without LE found it easier to "be themselves" at work, compared to workers with LE.[5] In Victoria, the creation of Australia's first dedicated Lived and Living Experience branch (situated within the Department of Health), was met with some resistance around understanding the role/purpose of LLE and the shifting of existing power structures within the Department.[41] Data capturing stigma and discrimination experienced by workers with LLE specific to the WA context are unavailable in the literature. However, focus groups carried out for this project revealed that stigma and discrimination in the alcohol and other drug sector in general, and towards LLE workers in the sector, is real and persists, both in subtle and open forms.

"There was the constant suggestion that my lived experience was the only reason I had my role, and if it wasn't for the fact that I had used drugs, I wouldn't be worthy of the role that I had."

"Well, [participant name] and I work in like a clinical setting, and so the stigma there is like, huge…from doctors and like, psychologists and things like that."

"Now that we have this point of care testing program, just as an example, peer workers are being trained in point of care testing and there are multidisciplinary teams where the clinical staff are actually quite territorial of the tasks that they own, and there's a lot of resentment to peer workers being upskilled in this area."

The participant acknowledged that not all organisations are like this, but that there was constant talk of examples where clinicians were territorial around the upskilling peer-workers. Echoing themes found in the international literature, the theme of LLE not being valued and respected the same way as professional or clinical skillsets was apparent in both the peer and leader focus groups. Both focus groups discussed the presence of an internal hierarchy within alcohol and other drug services between peer workers and non-peer workers. Participants in both groups described they had observed and/or experienced stigma from professionals such as doctors and psychologists towards workers in LLE roles in alcohol and other drug clinical settings. In the peer focus group, this included discussions around bullying within organisations from workers who didn't have LLE based on a lack of acceptance and devaluing of LLE work and its contribution.

Participants in the peer worker focus group reported being made to feel like they were *"..only here because of your LE"* by professionals who didn't have LE, with *"..the suggestion that you'd never be able to be part of high-level work/projects without it."* Participants in the peer focus group discussed how this lack of acceptance and respect towards LLE work resulted in territorial clinician behaviours, with some participants reporting clinicians were against peer workers upskilling. Other participants also wondered if barriers for training and career advancement opportunities for peer workers were possibly due to workplace stigma. The WANADA and AODCCC 2022 workforce survey did find that one of the barriers preventing people with LE from entering non-designated LE roles was having already self-disclosed personal LE, and the associated perception of since experiencing resulting stigma.[12]

In the leaders focus group, the underlying cause of persisting stigmatising attitudes of clinicians towards workers with LLE was hypothesised to be *"…informed by that very straight psychiatry background – they don't understand the perspective of people with an alcohol and other drug background."* Participants also reflected on how these attitudes derive from a broader stigmatisation of the alcohol and other drug sector in general, noting how the medical model does not refer to professionals in the alcohol and other drug sector as clinicians, despite clinical knowledge, but in contrast does refer to mental health doctors and specialists as clinicians. It should be noted that one participant at the leaders focus group did express a different experience, noting that stigma and discrimination towards workers with LLE were not prevalent within their current organisation, where LLE is valued.

Participants in the peer worker focus group also discussed concerns around being treated differently if their LLE status changed while in designated LLE roles. If *lived* (past) experience workers chose to disclose within their workplace that they were using alcohol and other drug again, they felt they went from being trusted to distrusted, and yet, if they were in *living* (current) experience roles and reported to their workplace they had stopped using alcohol and other drug, they feared for their job security. Conditional trust and concerns around job security based on non-static alcohol and other drug behaviours is not conducive to a safe and supportive work environment given the non-linear nature of the recovery journey.

Key finding 13
Stigma and discrimination towards alcohol and other drug workers with LLE persists within the sector globally and within WA, demonstrated by internal hierarchies within services and organisations between designated LLE and non-LLE workers. LLE is not accepted or respected by alcohol and other drug professionals in the same way clinical knowledge is, reflecting the broader cultural norm of valuing formal education over other forms of knowledge, and the external stigmatisation of the alcohol and other drug sector as whole in general *(Recommendations* 3 *&* 4*, Suggested Actions* 2 *&* 3*). Also see* Recommendation 6.

Key finding 14
Workers with LLE experience conditional trust issues in the workplace and fears around job security if they disclose that their alcohol and other drug use status has changed within their workplace. This is not conducive to a safe and supportive work environment given the non-linear nature of the recovery journey(Recommendation 3, *suggested action 9*).

Pay and employee benefits inequities between workers in designated LE roles and workers without LE are also a concern for some workers in designated LE roles,[3,24,28] despite sometimes performing equivalent duties to workers not in designated LE roles.[3,28] Evidence for this disparity is particularly evident in harm reduction services in Canada, where pay inequities, alongside lack of compensation and benefits, were reported as prominent issues impacting the everyday experiences of staff in LE roles.[3] Survey participants reported academic or professional workers were paid more for the same duties due to having higher education qualifications.[3] Participants highlighted that stigma, compounded by inadequate salaries and benefits, is a major challenge.[3] They frequently reported being undervalued and not taken as seriously as their academic or professional colleagues, receiving patronising responses and less recognition for their work despite the immense emotional labour

required.[3] In the US, peer providers are notably low-wage workers, often employed part-time to avoid jeopardising disability benefits or due to perceived employers' reluctance to offer full-time benefits.[24]

In Australia, national and WA specific data on pay and employee benefits within the alcohol and other drug workforce are missing, however the 2020 NSW Alcohol and other drug NGO Worker survey did echo international trends, finding that among workers who worked similar hours and had been in the sector a similar length of time, workers with LE were paid less than those without.[5] Workers without LE reported greater comfortability living on their pay compared to those with LE.[5] The ATDC 2023 TAS workforce survey looked at organisational capacity and plans to reimburse peer workers, and revealed that limited funding was a barrier. Only 8% of participating organisations had dedicated funding within their budgets to reimburse peer workers over the next 12 months. 25% planned to reimburse but did not have a budget for it, 16% were planning to apply for funding to afford peer worker reimbursement, and 25% said they do not plan to reimburse because they did not have a budget for it in their funding agreement.[19] Though these findings were specific to TAS, it is possible they may be similar in other Australian states.

Key finding 15
Pay and employee benefits inequities between workers in designated LE roles and workers without LE exist in other settings, but there is a lack of data available to explore this in the WA context (Recommendation 5).

Role ambiguity

Role ambiguity for designated LE job titles is cited repeatedly across the literature as a key issue.[8,11,16,21,27,30,38,39] Lack of clarity around role definitions and expectations reflects poor professional understanding of what LE workforces do and could do,[8,21,27,38] leading to conflicting workplace expectations,[38] unneeded worker pressure and frustration[21,27] and feelings of being undervalued.[21] This can contribute to suboptimal use of LLE in leadership roles. Literature on this topic in the WA context is missing, but this theme was also echoed in the peer focus group held for this project. Participants in the peer focus group expressed that clinicians don't understand the role of peer/LLE workers:

> *"It's feeling like an experiment – clinicians have no idea what our role is or what we should and shouldn't be tasked with".*

> *"I've got 3 or 4 different hats on all at the same time - just called a peer but I'm actually doing so many different things."*

Despite the significance of LE roles expressed within policy, limited understanding of the diverse and unique roles that individuals with LE may undertake persists[8] and seems to exist beyond the alcohol and other drug sector to LE workforces in health and social care in general.[39]

Incorporating LE staff without clear communication and expectations about the nature of the role is tokenistic,[3,39] accompanies a lack of supportive organisational infrastructure and can lead to workers performing tasks outside the prescribed role, resulting in diluted integrity of the LE workforce.[22,27] Tokenism not only undermines the value of the LE workforce[22,27] but can leave individuals feeling

frustrated and disempowered with the realisation that the (public-facing) progression towards change is performative rather than genuine.[39] While some services provide clear expectations, training, and peer mentoring to guide workers to develop relevant skills and LE professional identity, the literature suggests that the majority of workers are left to navigate their roles independently, which can hinder their professional growth and effective use of their expertise.[39]

While we do not have literature on whether this is the case in WA, participants in the peer focus group expressed that equitable access to professional development and skill development was needed for peer workers to develop their professional identity (and progress, if they wanted to). Frustration navigating unclear roles, a lack of supportive organisational infrastructure and feelings of being undervalued and disempowered are unacceptable and particularly so for workers often in early recovery, susceptible to additional psychosocial stress.[27] Participants in the peer focus group expressed that workplaces need to know *how* to work with peer and LLE workers, and that educating the rest of the alcohol and other drug workforce or hierarchy on their prejudice, what peer/LLE workers do and how to work with them, was needed. Participants unanimously agreed the onus for this work needed to be on the sector or organisational level, rather than on the peer workers themselves, with responsibility starting at the top of hierarchy.

> *"It's great to want to create all these roles and to have lived experience roles, but the bigger piece is the education – you can't put these roles in and not educate around why you're doing it…oftentimes people are like 'Well, what's your role? what do you actually do?' – There's no education around the reasoning for why we're there sometimes and I think that's the bigger piece that's missing."*

Key finding 16
Role ambiguity for designated LLE roles is a prominent issue and reflects poor professional understanding of what LLE workforces do. This leads to conflicting workplace expectations, unneeded worker pressure and frustration, and feelings of being undervalued by non-LLE staff (*Recommendations* 1, 3, 4 & 5, *and Suggested Actions* 2 & 4).

Insufficient training and support

Workers in designated LE roles can undertake emotionally laborious roles.[3] Employing empathy and the sharing of personal experience while maintaining professional boundaries with clients, all the while being aware of managing triggers and one's own risk of relapse, requires significant skilful negotiation.[24,28] When balancing LE roles and recovery, reconciling differences between personal and professional ideologies can be challenging for some workers with LE.[1,11] Workers with LE are exposed to grief and trauma[28] and can also work in high stakes contexts such as crisis response[21], which may link to their own related experiences.[21,28] As such, this highlights the need for sufficient training and workplace support. Unfortunately, lack of adequate training and support is recognised in the literature as another challenge faced by workers in designated LE roles.[11,16,21,27,38]

Inadequate training and support systems have been identified for LE workers participating in harm reduction roles,[21,38] where they risk overextending themselves beyond the requirements of the job in emotionally laborious and/or high-stakes environments (e.g. responding to out of hours overdose incidents).[21] In Canada, insufficient role support and training also contributed to workers with LE

feeling ineffectual and overlooked.[21] Interestingly, the 2020 NSW Alcohol and other drug NGO worker survey found that generally, staff felt highly and evenly supported in their role across organisational levels.[5] However, this cannot be generalised to the broader Australian workforce or to the specific LE alcohol and other drug workforce. In contrast, APSU (SHARC) in Victoria noted that most consumers in LLE roles have not been trained.[40]

In the WA context, the 2022 WANADA and AODCCC leaders survey reported measures in place for peer workers including supervision, training and mentoring opportunities (standard for all workers and further as required), dedicated peer programs, and partnering peer workers with other staff for extended learning opportunities and mutual support.[12] In the workers survey, the majority of workers noted that they received some form of supervision.[12] It is possible this may be echoed for workers with LLE, given that two thirds of the workforce reported LE, however this needs to be explored. Further data on the extent of training and support measures in the WA context and from LLE worker perspectives is missing from the literature, however participants in the peer focus group expressed there was a need for equitable access to PD and skill development for peer workers.

Key finding 17
Peer and LE workers undertake emotionally laborious roles requiring a skilful balance between purposeful sharing of personal experience, maintaining professional boundaries, and managing personal triggers and risk of relapse. Despite this, lack of adequate training and support is recognised in the literature as a challenge for LE workers. There are no data in the literature of the extent of this issue in the precise WA alcohol and other drug LLE context, but participants in the peer focus group expressed that there was a need for equitable access to PD and skill development *(Recommendations 2, 3, & 4, and suggested actions 5, 6 & 7.*

Limited career advancement and job insecurity

The MHC's National Lived Experience Workforce Guidelines 2021 noted that a lack of opportunities for career progression in the LLE workforce is a major barrier.[42] Literature from the U.S. and Canada also discuss limited opportunity for career growth in the alcohol and other drug LE workforce context.[3,24] Though literature on this topic is missing in the WA alcohol and other drug context, this was a theme that came up in the peer focus group held for this project. Participants described how the LLE label can open doors for people, providing opportunities for work in the alcohol and other drug sector as a peer or LLE worker despite not having formal academic qualifications. However, following this, there is very little opportunity for people to progress past the peer/LLE role. Participants described limited access to workforce development, PD and career advancement opportunities. In the context of LE becoming less relevant as time goes on, concerns around "what next" are expressed in the literature[3] and were also expressed in the peer focus group:

"When does my LE become irrelevant - after how many years?"

"Is it when you can no longer relate to current users?"

"If I have the experience but gaps in the education offered or training opportunities, what next?"

Participants also discussed the need to drop the LLE label in order to allow career progression, and questioned the labelling of LLE roles based on their LLE quality rather than based on the responsibilities of the role:

"The label defines YOU and NOT the ROLE – this is an issue."

"The label IS the problem – For example, my job title is "healing worker" rather than a peer or LE label. This is labelling the role for what it actually is, and this is empowering. I have disclosed LE and this brings value to the work, but I don't need the label. This enables career progression, for example, from healer to group facilitator (and this goes on your CV) – not just stuck as a "peer". I'm in a LE role because I want to help other people. I'm not just here because I want to be here due to my LE - so is the label needed?"

"I am more than my experience of shooting up."

Role titles based on duties and nature of the role, with recruitment statements encouraging application by those with LLE, were favoured in this discussion as a means to openly encourage people with LLE to consider roles beyond labelled roles. Standardised wording in all recruitment regarding LLE in the alcohol and other drug context, as similar to other priority groups, could potentially read as:

"We welcome applications from LLE and offer professional development, training, confidential wellbeing support through our EAP program,… We also ensure confidentiality regarding LLE disclosure."

Participants also discussed how job security concerns also arise due to the conditional nature of some LLE roles. If *lived* experience workers chose to disclose they were using alcohol and other drug again in their workplace, they felt they went from being trusted to distrusted, and feared for their job security. This also applies in reverse, when LLE workers are in *living* experience roles and report to their workplace they have stopped using alcohol and other drug, they fear for their job security. Participants also noted how other conditional elements of their employment were unjust and added to job security concerns.

"There are teachers, doctors, lawyers, GPs who use drugs so why is it: 'Only if you're 2 years into your recovery you can work here'?"

Conditional trust and concerns around job security based on alcohol and other drug behaviours is not conducive to a safe and supportive environment given the non-linear nature of the recovery journey.

This sense of thwarted ability for career advancement is further complicated by concerns around the LE label limiting individuals from changing career paths outside of alcohol and other drug LLE, due to external stigma. Participants in the peer focus group noted,

"You may not be able to change careers… the risk is if you want to work elsewhere there is fear of being discriminated against and you won't get a job – So you don't want that LE label impeding on your future. It limits you from changing career paths outside of alcohol and other drug *LLE."*

In response to the concerns of career restriction associated with the LLE label, participants in the peer focus group explored the option of providing choice at the individual level with regard to adopting LLE labels in role titles.

Barriers to career advancement opportunities for workers with LLE who choose to remain in the alcohol and other drug sector may partly be due to clinician gate-keeping (see *Stigma and discrimination* and *Role ambiguity*). Participants in the peer focus group discussed how some clinicians were against peer workers upskilling. Other participants also wondered if barriers for training and career advancement opportunities for peer workers stemmed from workplace stigma. The literature does also observe how a lack of non-LE workers understanding what LE work is, and a lack of acceptance and respect towards LE work, results in territorial clinician behaviours. If not due to workplace stigma, participants in the peer focus group wondered if they were excluded from training opportunities because they were designed for clinical workers. If so, participants felt that training would still be relevant for peers and questioned who determines access to what training.

"I don't know if this comes under stigma, but like, barriers to access, for training opportunities, for peers. I think, oftentimes there's quite a lot of training opportunities for clinicians, but I think oftentimes the thinking is that the training is not suitable for a peer. – But, as a peer you're exposed to a lot of that. The training might be designed for clinicians, but it might be really helpful for your role. I often wonder what's the decision making around who decides that it's not suitable for a peer to sit in?...The decision is being made by someone who's not got LE."

The WANADA and AODCCC 2022 workforce survey found that perceived concerns of experiencing stigma due to self-disclosure of personal LE was another barrier preventing people with LE entering non-designated LE roles.[12]

Given the current system necessitates acquiring qualifications in order to advance careers, obstacles and opportunities for further training and qualifications for workers with LLE need to be identified in the WA alcohol and other drug context, and career progression pathways developed. Further work beyond the scope of this project is required to explore this issue.

"There are peer workers here, and there are management teams here, where are the middle steps?"

Key finding 18
While LLE role labelling may enable career opportunities despite not having formal academic qualifications, the label may stifle career progression within both the alcohol and other drug sector and externally (Consideration 1).

Key finding 19
A lack of opportunities for career progression is a challenge for the alcohol and other drug LLE workforce. Barriers to career advancement opportunities for workers with LE may partly be due to a lack of understanding and acceptance of what LE workers do, stigma, and resulted clinician gate-keeping (*Recommendation 2, 3 & 4, and suggested actions 2 & 10*), and the current structures and requirements for career advancement (Recommendation 5, *suggested action 11*).

Key finding 20
Concerns around job security for workers in LLE roles arise due to an individual's LE becoming more dated, the conditional nature of some LLE roles, and concerns around stigma preventing individuals from changing career paths outside of alcohol and other drug LLE *(Recommendations 2, 3 & 4, and suggested actions 6, 9 & 10)*.

Barriers for LLE Leadership

Understanding and enabling LLE leadership is hindered somewhat due to the very limited specific literature on leadership within the alcohol and other drug LLE workforce context. The sociocultural norm of favouring formal education over experiential knowledge plays a role in limiting opportunity for LLE leadership.[43,44,45,46] This is compounded in the alcohol and other drug sector by the challenges faced by the designated LLE workforce in general, which do not create a supportive environment from which career advancement, and leadership, can evolve. Stigma and discrimination, role ambiguity, a lack of adequate training and workplace support, and limited career advancement options do not foster a sense of feeling respected, valued, safe and empowered.

The need for facilitating a safe and supportive environment as a necessity for meaningful engagement with the LLE workforce and as a foundation for LLE leadership was noted in the leaders focus group held for this project. Participants agreed that this would take a system wide approach:

"To ensure safety, you can't engage a person; you need to engage a system."

Addressing stigma and role ambiguity through visible managerial support, clear LLE job descriptions, policy, and whole of workforce training on the role and value of LLE workers and how to work with them are some such strategies that may raise respect and recognition for LLE workers in the sector, leading to greater empowerment and acceptance. Strategies such as adequate training for LLE workers, supervision and professional development can also foster a supportive and empowering environment for workers with LLE. These strategies are further explored in *Suggested actions to support the implementation of recommendations 1-5*.

Leaders in the focus group explained how their LLE was just one contributing component of a broader skillset they utilised for leadership, noting that support and training to develop other sector relevant skills is needed to develop leadership. A lack of opportunities for upskilling and career progression has been named as a major barrier for developing greater designated LLE leadership roles.[47] This further emphasises the need for LLE workforce training, increased access to upskilling and professional development opportunities and development of career pathways. At present, most alcohol and other drug designated LLE roles are entry level, with few leadership roles available and unclear career progression pathways. The current system in general requires further training and qualifications to advance career, therefore obstacles and opportunities for progression and leadership need to be identified, and solutions for safe and meaningful career pathways further explored in consultation with key stakeholders.

Focus group participants also explored the possibility of alternate models and dynamic processes bringing together LLE expertise and professional expertise to foster greater LLE leadership, and these are explored along with similar systemic change recommendations from the literature in *Recommendation 6*.

Despite these challenges for the LLE workforce and leadership, there are leaders in the sector, including in WA, with LLE (but not necessarily in LLE designated/labelled roles). Though there are no specific data on the number of leaders in WA with LLE, the available research consistently suggests about two thirds of the sector possess LLE. During the consultations for this project, it was clear that there are many key people in alcohol and other drug leadership roles who possess LLE.

Key finding 21
Very limited literature on leadership within the alcohol and other drug LLE workforce context and a broader sociocultural framework of valuing formal education over experiential knowledge contribute to limited LLE leadership. Challenges faced by the alcohol and other drug LLE workforce more generally, such as stigma and discrimination, role ambiguity, a lack of adequate training and workplace support, and limited career advancement options also do not foster a sense of feeling respected, valued, safe and empowered, from which leadership can develop. Addressing these is deemed necessary to facilitate a safe and supportive foundation for leadership *(*Recommendations 1-5*, suggested actions 1-11)*. Further, systemic changes may foster greater alcohol and other drug LLE leadership *(*Recommendation 6*)*.

Similarities and Differences to the Mental Health Sector

Historical differences

Workers with LLE are also part of other fields including the mental health workforce.[1] Similar to alcohol and other drug LLE workers, mental health LE workers have been shown to benefit consumers and the sector by fostering empowerment and hope in clients, decreasing consumer social isolation, increasing understanding between service providers and users, enabling more meaningful, satisfying and effective service provision, and ultimately, improving outcomes for service users including reduced hospital admissions and stay lengths.[48,49] An important point of difference exists in that LLE work in mental health services has been a more contemporary movement,[2,50] whereas LLE workers have been drivers of and/or heavily involved in alcohol and other drug services and treatment since the inception of the field.[1,2,5,50] The more recent integration of LLE workers in mental health services and treatment has possibly been driven by high dissatisfaction with traditional services provided and the need for new, effective approaches.[51] Participants in the leaders focus group discussed their frustration with the relatively modern term LE/LLE, as it comes from the mental health sector and implies that incorporating LLE is a newly invented phenomenon, whereas LLE in treatment and services is at the foundation of the alcohol and other drug sector:

> *"The LE label is insulting because it's come from the mental health sector as though they've just invented it, when, actually, LE has been around forever in AOD. The roots of the AOD sector is LE."*

Discomfort exists around this term in the alcohol and other drug sector and participants suggested instead working towards something with more acceptability in the field. Importantly, participants believed that, at least, the term LLE should be used instead of LE, acknowledging that the recover journey is not static.

Key finding 22
LLE work in the alcohol and other drug sector has existed since the inception of the field. Incorporating LLE workers into mental health services is a more contemporary movement. As such, there is discomfort using the term "LE/LLE" in an alcohol and other drug context. LLE is the preferred term over LE, acknowledging that the recovery journey is not static *(*Consideration 2*)*.

Similar challenges

Similar challenges, such as stigma and discrimination, role ambiguity, lack of understanding, respect and valuing of LE roles by clinicians, lack of suitable training and support are commonly reported in studies of LE workers in the mental health sector.[1,44,48,49,52,53,54,55] LE workers in mental health often face internal hierarchies and biases, whether subtle or overt, from their non-peer colleagues and leaders within their organisations,[53,54,55] as has been observed in the alcohol and other drug sector. Research on reducing stigma in mental health services found the theme of othering or disidentification between peers and mental health professionals.[55] A lack of standardised training and formal theory in both mental health and alcohol and other drug LLE work results in disparity in the readiness of LLE workers,[56] contributing to professionals perceiving LE roles as lacking credibility.[13,56,53,54] The mental health literature documents peer workers being perceived as "patients" or "pseudo-staff," and facing scepticism regarding their emotional resilience and professional credibility.[53] In the WA context, some participants at the leaders focus group noted how this internal hierarchy between workers with and without LLE and associated stigma exists within both alcohol and other drug and mental health services.

Key finding 23
Despite the apparent longer history of LLE leadership roles in the alcohol and other drug sector**,** mental health LLE workers face similar challenges as LLE workers in alcohol and other drug including stigma and discrimination, role ambiguity, lack of understanding, respect and valuing of LLE roles by clinicians, and lack of suitable training and support.

LLE leadership in mental health

In the mental health sector, the status of LLE leadership remains limited, with LLE roles primarily occupying entry-level positions and facing significant barriers to career advancement,[49,52] of which have also been described for alcohol and other drug LLE. Although LLE leadership roles are present in Australia's mental health service delivery, they are still more of an exception than a standard practice.[49] In contrast, the USA has seen a more developed integration of LLE leadership within formal positions such as board members, directors, and managers, particularly within the large number of consumer-run organisations (CROs), which play a central role in planning and delivering peer-based services.[52,57] Despite this evidence of effective peer-based mental health collectives and organisations ran by LLE workers, there is a lack of research on LLE leadership in mainstream organisations.[57] This may reflect reservations about LLE leadership, which are still apparent in traditional settings.[57]

Roles created for LLE workers and leaders in mental health also risk tokenism,[43,49,58] as has been discussed in the alcohol and other drug context and was flagged as a concern by participants in the consumer, peer and leader focus groups. Hiring one single person to represent the diversity of LLE across a range of committees or projects to meet accreditation standards is a tokenistic function.[43,58]

This sentiment was also echoed in the alcohol and other drug peer, leader and consumer focus groups held for this project. In South Australia (SA) the Activating Lived Experience Leadership (ALEL) project identified this was already occurring.[43] People with LLE must be hired with intention,[58] provided with adequate support, training and supervision,[58] and perform in roles with "real-world" impact.[49]

In Australia, the emergence of executive-level LE roles within certain not-for-profit and public mental health services has resulted in greater recognition of the value of LLE roles.[49] This has had a cascade effect where hiring further workers with LLE became a higher priority.[49] This is worth consideration as a mechanism to increase LLE in the alcohol and other drug workforce in WA. However, hiring many people with LLE risks tokenism and may not illicit desired changes in organisational practices if they are not provided with adequate support, training and supervision,[58] and performing in roles with "real-world" impact.[49]

Key finding 24
The status of LLE leadership in mental health in Australia, although expanding, remains limited, and may reflect traditional reservations and associated stigma about LLE leadership. LLE roles primarily occupy entry-level positions and face significant barriers to career advancement, which have also been described for alcohol and other drug LLE.

Key finding 25
Hiring one single person to represent the diversity of LLE in mental health across a range of committees or projects to meet accreditation standards is tokenistic. This sentiment is also echoed in the alcohol and other drug sector. However, creating executive-level LLE roles may have a positive influence in fostering LLE worker acceptability and growth of the LLE workforce if the role is created with set intentions and purpose, supported with adequate support measures and training, and is able to impart 'real-world' impact. This is worth consideration as a mechanism to increase LLE in the alcohol and other drug workforce in WA *(*Recommendation 6*)*.

Strategies to address key challenges of the mental health LLE workforce

Strategies in response to key challenges for the mental health workforce, such as stigma and role ambiguity, are similar to those reported in the alcohol and other drug literature. These include adequate support, supervision and training for LLE workers, clear roles, education and training for staff without LLE on LLE work, and demonstrated managerial support of LLE workforces, cultivating positive and safe workplace cultures.[43,52,53,55,59] Specifically, education for non-LLE workers should demonstrate diverse positions and social roles held by those with LE.[55] As well as ensuring LLE workers receive adequate support and training, demonstrated managerial and organisational support of LLE roles in mental health may also include the employment of LLE workers in senior/leadership roles, including management positions.[55]

When leaders promote the LLE workforce, there is a cascade effect of greater acceptance. [43,52] Again, this should be considered in the alcohol and other drug context. With regard to training for LLE workers, there is similar dialogue in the mental health space as in alcohol and other drug around the pros and cons of professionalisation. A lack of standardised training and formal theory in both mental health and alcohol and other drug LE work results in disparity in the readiness of LE workers[56] and contributes to lack of perceived credibility by non-LE workers.[30,54,56] However, while

professionalisation may elevate credibility in the system,[30,54,56] standardising the LE profession carries the risk of diluting the nature of peer work.[54,32] This same dialogue is present in other LLE workforces also, including for HIV peer workers.[60] Further, there is also the risk that potential organic advancement based on development and career experience, that may come as the relevance and currency of LLE is diluted over time, is narrowed if LLE-specific professionalisation is the focus.

Key finding 26
Strategies in response to key challenges for the mental health workforce, such as stigma and role ambiguity, are similar to those reported in the alcohol and other drug literature. These include adequate support, supervision and training for LLE workers, clear roles, education and training for staff without LLE or LLE work, and demonstrated managerial support of LLE workforces, cultivating positive and safe workplace cultures.

Key finding 27
Lack of professionalisation of the mental health and alcohol and other drug LLE workforces results in disparity in the readiness of LLE workers and contributes to lack of perceived credibility by non-LLE workers. While professionalisation may elevate credibility in the system for both mental health and alcohol and other drug LLE workforces, standardising the LLE profession carries the risk of diluting the nature of peer work *(*Recommendation 3, suggested action 6*)*.

Strategies to enable LLE leadership in mental health

Beyond implementing the above strategies to reduce stigma and discrimination, increase support and training of LLE workers, and clarify LLE roles, structural systemic changes hold potential to enable LLE leadership in mental health. Given the crossover between challenges and proposed solutions faced by alcohol and other drug and mental health LLE workforces & LLE leadership, these strategies should be considered in the alcohol and other drug context.

Increased embedding of LLE roles in the mental health sector is one illustration of such a strategy and may include establishing senior leadership positions with the power to make decisions and allocate budget resources and enabling local LLE initiatives.[43] As noted earlier, employment of LLE workers in senior/leadership roles in mental health, including management positions, can result in a cascade effect of greater acceptance of LLE workers.[43,52] Again, this is worthy of consideration in the WA alcohol and other drug context and was discussed in the focus groups. Further, given the existing activity of LLE workers in the mental health sector in advocacy and education, it is worth considering how systems can create career pathways for service and policy leadership positions, with these activities as stepping stones.[61]

Medical and other clinical hierarchies - where power dynamics devalue LLE perspectives in favour of health professionals' knowledge - has been the long-standing organisational model in mental health,[54,59] and it has been argued its traditional power disparities continue to be reproduced.[62] As such, organisational systemic cultural change has become a challenge to achieve.[54,63] The mental health literature suggests the restructuring of traditional hierarchies to enable LLE leadership.[29,44] Restructuring by adopting democratic or horizontal hierarchy models in mental health services, organisations, and policy agencies shifts power and fosters the valuing of consumer participation and LLE knowledge as equal to professional knowledge.[29,44] Flattened hierarchies significantly

enhance consumer involvement and improve service outcomes,[29] whereas steeper hierarchies may hinder organisational communications.[64]

Shifting away from traditional, entrenched medical hierarchies toward more egalitarian structures fosters genuine LLE participation rather than tokenistic involvement.[44] Such models encourage a cultural shift within organisations, potentially overcoming the barriers of entrenched medical hierarchies that have historically devalued consumer and LLE insights.[29,44] This democratic approach could be equally beneficial in the alcohol and other drug sector, as it reduces hierarchical obstacles, and ensures that LLE perspectives are integrated into decision-making processes, ultimately leading to more responsive and effective services. This suggests that this consideration should be discussed with alcohol and other drug key stakeholders.

Alternative models of hierarchical structures that enable power distribution/consumer decision-making power in mental health that may apply include financial models, driven by consumer leader approval controls, and electoral models, where board members for an organisation are elected every 3 years by people with LLE.[59] Such models redistribute power and ensure people with LLE hold decision-making power in mental health organisations.[59] Given the existing professional dominance over LLE workers in the traditional medical hierarchy, establishing flattened hierarchies with shared leadership presents a challenge.[54] Doing so requires a relinquishing of some of the power held by mental health professionals and professionals fostering greater acceptance of LLE knowledge.[54] As such, it is argued that strategies must focus on shifting professionals' cognitions and attitudes to foster a more equitable and collaborative environment.[54] Alternative models of hierarchical structures and other means by which organisations may ensure power is not stabilised too long and LLE perspectives are not suppressed by hierarchical structures should be considered in the WA alcohol and other drug context.

Key finding 28
Structural systemic changes are proposed in the mental health literature as a means to enable mental health LLE leadership. These include creation of leadership career pathways utilising existing activities undertaken by LLE workers such as advocacy and education *(*Recommendation 5*, suggested action 11)*, increased embedment of LLE roles, and restructuring of traditional medical hierarchy towards more democratic and horizontal power structures (Recommendation 6*)*.

Supporting ways of working with people, leaders and experts with alcohol and other drug LLE.

In supporting ways of working with people, leaders and experts with alcohol and other drug LLE, there are four suggested areas for attention:

a) Key considerations around LLE terminology and labelling
b) Recommendations: Six recommendations suggesting safe and effective ways of working with people, leaders and experts with alcohol and other drug LLE, at a systems, organisation/service and individual level
c) Suggested actions addressing the key challenges faced by the LLE workforce and leadership. These actions guide implementation of Recommendations 1 to 5

d) Further potential mechanisms to enable LLE leadership. These mechanisms guide implementation of Recommendation 6

Key Considerations Around LLE Terminology and Labelling

Consideration 1: In response to concerns of career restriction associated with the LLE label, the option of providing choice at the individual level with regard to adopting LE labels in role titles should be explored.

Consideration 2: It is worth considering a substitute term for LE/LLE with greater acceptability in the alcohol and other drug context.

LLE work in the alcohol and other drug sector has existed since the inception of the field.[1,2,5,50] There is some contention about adopting the term "LE/LLE" in a WA alcohol and other drug context, as it is a term that is perceived to have come from a more recent movement within mental health.[2,50] As discussed in the leader focus group, the term does not necessarily fit within the alcohol and other drug sector nor reflects a different history.

Leaders focus group participants discussed their frustration with adopting the relatively modern term LLE, as it implies that incorporating LLE is a newly invented phenomenon, whereas LLE in treatment and services is at the foundation of the alcohol and other drug sector. Similarly, peer focus group participants questioned the purpose of using the LLE terminology and labelling given two thirds of the alcohol and other drug workforce report LLE.

Participants in both the peer and leader focus groups also took issue with the terminology in that a person's LLE may have occurred in the distant past with less relevance in current circumstances. Concerns arose around using the LLE label if the relevance of one's LLE was lessened with time (see *Limited career advancement and job insecurity*).

Peer focus group participants also noted that while LLE role labelling may initially enable career opportunities despite not having formal academic qualifications, the label may stifle career progression within both the alcohol and other drug sector and externally.

"I did my final prac at [peer organisation] as a peer worker, and now that I've got a job as a counsellor and I've graduated, I've had to almost drop like, that lived experience title..."

Participants discussed the need for some distance from the LLE label to allow career progression and questioned the labelling of LLE roles based on their LLE quality rather than based on the responsibilities of the role. Role titles based on duties and nature of the role, with recruitment statements encouraging application by those with LLE, were considered as a means to openly encourage people with LLE to apply for roles where drawing on LLE was a duty or of benefit to the role. Standardised wording in all recruitment regarding LLE in the alcohol and other drug context, as similar to other priority groups, could encourage application by people with LLE, without perceived concerns round stigma or negative career implications. Individuals could then negotiate role titles with their employer, choosing whether to have LLE in their role title.

In response to the concerns of career restriction associated with the LLE label, peer focus group participants explored the option of providing choice at the individual level with regard to adopting LLE labels in role titles.

"What about giving them the choice of putting LE/LLE at the end of their title…Individuals should be able to negotiate their job title with their employer – it doesn't need to be labelled!"

Further to this, and paramount within all three focus groups, was that a single LLE label cannot capture the diversity of LLE within alcohol and other drug. As such, participants took issue with the label potentially being used in a representative context by one or a small number of individuals, who would not be able to accurately represent the diversity of LLE across different types of substance use, personal and family LLE, regional and metropolitan areas, and past and current issues affecting alcohol and other drug users.

Finally, participants in the peer and consumer focus groups also spoke of the conditional elements of employment the LLE label perpetuates, with a lack of acceptance of fluidity between *Living* and *Lived* experience role types being misaligned with the non-static journey of recovery. While it is important to note that a few participants in the focus group felt the LLE terminology and label could be empowering (if given appropriate recognition and paid appropriately), the theme of the label being restrictive was the dominant dialogue.

In response to the concerns associated with the LLE terminology and labelling, participants in the leaders focus group suggested working towards terminology with more acceptability in the field. If the LLE terminology persists, LLE is the preferred term over LE, acknowledging that the alcohol and other drug recovery journey is not static. Further discussion, consideration and time is ideally required to work towards universally accepted terms.

Recommendations Addressing the Key Challenges Faced by the LLE Workforce and Leadership

Recommendation 1

Recognise that LLE engagement in the alcohol and other drug sector differs from the mental health and indeed other sectors specifically because most alcohol and other drug services in WA have emerged from LLE leadership and a large proportion of the existing alcohol and other drug workforce identify that they have LLE (even when that is not a specific element of their role). In addition, the legal status of drugs and associated stigma, discrimination and vulnerabilities for those who identify as having LLE and the diversity of experience, wants and needs in relation to alcohol and other drug use and related harms, create distinctions with other sectors that seek to draw on LLE. It is important to ensure a dynamic process with the alcohol and other drug sector to refine the role of specifically identified LLE leadership roles (including role terminology) and their relationships to the current workforce that identifies as having LLE. Initial targets for action include:

- mapping LLE, LLE expertise, and formal and informal access to this expertise in the alcohol and other drug sector in WA
- agreeing formal terminology, roles and role descriptions for LLE leadership roles in the alcohol and other drug sector
- establishing LLE leadership roles in governance, policy and practice leadership sectors

Recommendation 2

Develop an ongoing strategy to identify the diverse contributions of the LLE workforce and leadership in the alcohol and other drug sector, including clear evidence of the benefits and impact and related challenges. This information should be used to tailor responses to the specific workplace support, education, training, supervision and professional development needs of LLE roles and leadership contributors. Strategies to develop role confidence, role competence and role legitimacy will be critical in this respect as will be strategies to ensure job and role engagement and security.

Recommendation 3

Ensure training and management and governance structures and practices legitimise the LLE workforce and leadership role across the general alcohol and other drug workforce. This is inclusive of planning and contracting services in WA as well as associated services (e.g. mainstream health and intersecting areas such as homelessness and family and domestic violence, etc). Key issues might include role legitimacy, respect and acceptance of LLE roles, preventing and reducing stigma; and issues that might arise in relation to role ambiguity. A key starting point in relation to the latter would be to use the information in this report to inform negotiation across sectors to establish and maintain effective LLE leadership roles. Ensure all measures to maintain acceptance and role legitimacy reflect acceptance of fluidity between *living* and *lived* experience.

Recommendation 4

Identify and develop responses to challenges to embracing LLE roles, including leadership roles. This will include: responding to risks of and evidence of stigma and discrimination; responding to existing role ambiguity; addressing the vulnerabilities of embracing a LLE leadership role including disclosure of activity that is contrary to current legislation and disclosure of behaviours that are considered to be among the most stigmatised in the world; mapping, establishing and maintaining support and supervision mechanisms; strategies to prevent and address burnout; and strategies to ensure credibility and acceptance of LLE.

Recommendation 5

Role security, renumeration and employee benefits should reflect role demands and ensure that inequities with similar role levels are avoided. Equitable job security, pay and other rewards are critical to legitimise and recognise the value of the LLE workforce and in particular, LLE leadership roles. This will require investment in considered and co-designed development of LLE leadership role descriptions and agreed understanding of role clarity, expectations and performance measures. It will also involve identification of implications of the LLE leadership role for career development and advancement. Equitable access to professional development, skill development and career pathways will need to be identified, developed and maintained.

Recommendation 6

Embed LLE systemically and safely, adopting a collective approach to LLE leadership. This requires structural change to address inequities through the purposeful creation of senior leadership roles, increasing LLE representation in decision-making bodies, fostering shared leadership between LLE and professional/academic knowledge, and creating LLE roles at all system levels to enhance power and influence. Additional actions might involve implementing dynamic, issue-specific advisory groups with an LLE leadership "connector"/coordinator role, ensuring abundant and diverse

representation to reflect the breadth of LLE experiences, and exploring alternate governance models such as financial or electoral systems.

Suggested actions to support the implementation of recommendations

Eleven actions relate to recommendations 1-5:

1. **Mapping LLE, LLE expertise, and formal and informal access to this expertise in the alcohol and other drug sector in WA (supports recommendation 1)**

While there is a consensus within the WA alcohol and other drug sector that people with LLE work in varying roles, including in a leadership capacity[41] quantitative data on role types and distribution of roles within the LLE workforce specifically are missing from the literature. To better understand the LLE workforce size and characteristics, and the differences between workers with and without LE[1] further research mapping the WA alcohol and other drug workforce is necessary. Mapping the extent and breadth of roles within the LLE workforce specifically has potential to decrease the stigma surrounding alcohol and other drug use, to acknowledge and legitimise the value of LLE in the workforce[1] and to identify and address gaps in LLE across service, sector and system levels.

2. **Whole of workforce training (supports recommendations 3 & 4)**

Providing foundation training to the whole alcohol and other drug workforce on the alcohol and other drug LLE workforce, its purpose, and value, is recommended in the literature as a strategy to reduce stigma and discrimination, [2,10,25,40,42] and to improve the issue of role ambiguity for designated LLE roles,[25,38,40,42] legitimising the LLE workforce and leadership. Indirectly, such a strategy could also increase career advancement opportunities for workers with LLE by reducing prejudices and perceived gatekeeping of training opportunities by clinicians (see Limited career advancement and job insecurity). This strategy was also supported in the peer focus group. Training will need to take place across the whole workforce given the lack of clear distinction between workers with and without LE, to protect the anonymity and autonomy of workers with LE.[1] Training may also need to be considered with associated services (e.g. Housing; mainstream health).

Providing comprehensive training across the wider organisation, rather than limiting it to LE workers alone, can enhance the respect, acceptance and incorporation of LLE staff while reducing stigmatising attitudes among non-LE employees, fostering a more inclusive, safe workplace.[25,38,39,40,42] In addressing the role ambiguity issue, research indicates that training ensures professionals understand the parameters of LLE roles and as such, boundaries of the role are respected.[25,38,40,42] Importantly, whole of service foundation training can ensure staff understand how they may adapt their practice to support LLE workforces.[42] Participants in the peer focus group expressed support of education and training as a means to combat stigma and increase LLE role credibility and respect:

"Workplaces need to know how to work with peer workers and educate people about their prejudice. They need to educate the hierarchy not the peer workers themselves."

All participants agreed the onus should be on the sector and/or organisations to address these issues, with responsibility starting at the top of the system, and not on workers in designated LLE roles themselves. Participants also voiced concerns that such training and education initiatives could become a tick-box exercise without real and meaningful effects.

Models from the U.S. demonstrate that training staff and leadership on the role of peer providers can address stigma before peers are introduced into the workplace.[24] The Mental Health Commissions (MHC) 2021 LE Workforces Framework also lists whole of workplace LE education and training as one strategy to demonstrate organisational value of LLE workers.[42] Following the framework, one initiative reflective of this has been the development of the Peer Work Positives training by Consumers of Mental Health WA (CoMHWA). This training is intended to develop the readiness of both government and non-government organisations that currently employ or are considering employing LLE workers, and can be customised to domains including human resources, management and service delivery.[42]

This training is not alcohol and other drug specific but could be considered. In Victoria, training and education around LE workforces have recently been introduced (March 2024) as part of professional development for staff at Victorian Alcohol and Drug Association (VAADA)[41] and in Queensland, Queensland Health's Centre for AOD Workforce Development and Training, Insight, has recently launched a new e-learning module titled "Understanding the AOD Lived/Living Experience, Peer Workforce".[65] This module is aimed at workers in the alcohol and other drug, mental health, and social and emotional wellbeing (SEWB) fields .[65] It offers a comprehensive overview of the alcohol and other drug LLE and peer workforce, covering its history and current integration.[65] The module outlines the benefits of incorporating an alcohol and other drug LLE workforce into an organisation and provides guidance on the processes for sustainably embedding this workforce within organisational structure.[65]

The responsibility of development and dissemination of such training in the WA alcohol and other drug context would need to be considered further. Australian peer-led initiatives, such as those by APSU (SHARC), where consumers train professionals on consumer-participation practices, highlight the value of LLE staff in educating and driving cultural change.[40] A similar approach could be applied, with individuals with alcohol and other drug LLE delivering training on the LLE workforce to the broader alcohol and other drug workforce.

3. Policy mapping and development as required (supports recommendations 3 & 4)

Language and policy must also be considered when addressing the broader context of stigma and discrimination to enable legitimisation of the LLE workforce and leadership. Policy should address non-stigmatising language and the facilitation of open reporting of stigmatising behaviours.[5] Mapping existing policy addressing stigma across WA services and organisations would provide insight into where further policy development or implementation is required. Reporting and monitoring systems should be reviewed to ensure organisational Key Performance Indicators include anti-stigma actions.[10] Consumers and workers with LE should participate in the development of policy addressing stigma and discrimination.[10]

4. Clear LLE job descriptions and role clarity (supports recommendations 1, 3, 4 & 5)

Incorporating LLE staff without clear communication and expectations about the nature of the role is tokenistic[3,39] and reflects poor professional understanding of what LE workforces do.[8,21,27,38] Clear job descriptions and defined responsibilities for LLE workers are necessary to promote understanding, acceptance and valuing of the LLE workforce and to prevent overextension beyond role parameters.[8,16,25,28,39,42,66]

Educational resources reducing LLE role ambiguity and increasing understanding of the LLE workforce exist in the Australian context and could be used within WA services and organisations. The ADF have a LE guide designed for services describing the range of roles LE workers may undertake, detailing peer work through to advocacy and leadership.[66] The guide details key factors to ensure effective integration of people with LE, addressing clear role descriptions and recruitment processes, organisational leadership support, and the role of a dedicated program coordinator.[66] ATDC (TAS) also have a tool designed for organisational reflection and awareness surrounding best practice in LE participation, titled "The Lived Experience Participation Self-Assessment Review".[19]

5. Mapping of existing LLE workforce support, training, supervision and PD (supports recommendations 3 & 4)

Mapping the types, extent of practice and benefits of workplace support, education, training, and other professional development available to workers with LLE in the WA alcohol and other drug sector will allow the identification of gaps and can be used to inform any further development of appropriate workplace support and development practices and processes. Professional development and other workplace supports for the LE workforce including LLE leadership should be customised to meet the unique needs of the alcohol and other drug LLE workforce.[1] Effective workforce planning and development require precise and current data to determine the best ways to engage and get the best outcomes from these workers.[1] Recruitment, retention, and wellbeing initiatives for the alcohol and other drug workforce, including the alcohol and other drug LE workforce, are also constrained in their scope and effectiveness due to insufficient data on workplace wellbeing factors, including potential differences between those with personal LE, other types of LE, and those without any LE.[1]

6. Training for workers in designated LLE roles (supports recommendations 2, 3 & 4)

Organisational mechanisms such as LLE education, training and supervision are recognised as a means to support the designated LE workforce, reduce associated challenges and establish professionalism.[8,16,24,38,39,40]

The importance of training for the LLE workforce in LLE designated roles, their professional colleagues and organisation leaders is highlighted across the literature to support LLE workers to carry out their roles, reduce role ambiguity and elevate professional credibility. [8,16,24,38,39,40] This has not yet transitioned into practice and there is a lack of program development and/or availability.[38] While some services provide clear expectations, training, and peer mentoring to guide workers to develop relevant skills and LE professional identity, the literature suggests majority of workers are left to navigate their roles independently, which can hinder their professional growth.[39] APSU (SHARC) note that most consumers in LLE roles have not been trained.[40] Training for people in designated LLE roles needs to include education on organisation structure and processes, policy, planning and resources.[40] Especially critical to the initial training of workers in these roles is an emphasis on self-care and safe self-disclosure.[38] Training on how to safely, purposely and meaningfully share personal stories is essential to ensure the fundamental nature of peer work is preserved.[38] Participants in the leaders focus group also highlighted this, noting Hope foundation in WA conduct this training. In Australia, SHARC have reported on developing introductory training for the workforce in designed LLE roles, and list the following content inclusions:

"…role types and core concepts of LLE work, training on purposeful disclosure, working with others (boundaries, trauma-informed care, recovery capital [understanding available resources]), communication training, diversity, inclusion and ethical practice, AOD LLE history and purpose, navigating service systems, understanding treatment streams, knowledge around AOD substances, safety & legislation, self-care, support and professional development, and advocacy training."[67]

While some of the literature does note the potential risk of professionalisation of the alcohol and other drug workforce in designated LE roles diluting the essence of peer provision,[8,24,29] support for the measure of workforce training is present from Australian peer-led alcohol and other drug organisations.[25,40,66,67] This same dialogue around the advantages and disadvantages of professionalisation of LLE workforces also exists in other health sectors including mental health[30,54,56] and HIV.[60]

In their report on developing introductory training for the LE workforce, SHARC explain training should be developed and delivered by LE workers with workplace experience and training expertise.[40] In Victoria, workforce specialist educators are funded by the Department of Health, who are tasked with strengthening capacity to create and provide training.[40] SHARC also highlight the significance of regular evaluation and updates to training programs as the LLE workforce continues to evolve.[40] Such training programs and supporting infrastructure could be utilised or adapted for the WA context to develop the existing LLE workforce and to enable clear career pathways to sector employment for service users and others with LLE.

7. LLE-led supervision for workers in designated LLE roles (supports recommendations 2, 3 & 4)

A lack of adequate supervision has come up in much of the literature. As such this specific practice will be focused on here in more detail.

In response to a noted lack of adequate supervision in the literature, formal supervision and monitoring processes are recommended as organisational mechanisms to support the LLE workforce and associated challenges with support and role ambiguity.[16,25,27,40,42] The ADF note the importance of having a dedicated program manager in place for effective integration of LLE workers as well as access to support from the organisation's leadership team.[66]

Some of the literature further argues supervision should be carried out by senior LE workers rather than professionals in clinical roles.[25,27] Experienced workers in LE roles are best positioned to support LE workers, and professionals in clinical roles are less relevant to LE roles and thus inappropriate to provide effective supervision.[25,27] APSU (SHARC) suggest supervision should be carried out independently from the relevant organisation, to ensure LLE workers can discuss concerns openly.[40]

8. Demonstrated managerial support (supports all recommendations)

The mental health literature demonstrates that managerial support of LLE workforces cultivates supportive and safe workplace cultures, reducing stigma and discrimination and promoting greater understanding of LLE roles.[43,52,53,55,59] When leaders promote the LLE workforce, there is a cascade effect of greater acceptance.[43,52] The significance of managerial commitment for effective LLE participation is also observed in the alcohol and other drug sector,[4,40] with participants in the peer focus group noting that initiatives to create a safer environment for LLE workers needed to start from the top down.

9. Job security, unconditional on current LLE status (supports recommendation 3)

Workers in designated LLE roles experience fears around job security if they disclose that their LLE status has changed between lived and living (and reverse) within their workplace (see *Stigma and discrimination*). This is not conducive to a safe and supportive work environment given the non-linear nature of the recovery journey. Ensuring job security remains despite the non-static nature of recovery, promotes acceptance of fluidity between *living* and *lived* experience within LLE designated roles.

10. Equitable access to PD and skill development for career progression (supports recommendations 2, 4 & 5)

Further training and professional development is required for LLE workers to move into higher level participation roles such as committee members and group facilitators.[40] In Australia, APSU (SHARC) have developed a series of workshops titled 'Experts by Experience' to this effect, focusing on content such as the alcohol and other drug service system, alcohol and other drug policy and advocacy and safe and effective meeting participation, delivered as a series of workshops[41]. Evidence of effectiveness or attractiveness was not found.

Barriers to career advancement opportunities for workers with LLE who choose to remain in the alcohol and other drug sector may be due to a lack of acceptance and respect towards LLE work by clinicians, resulting in territorial clinician behaviours (see *Stigma and discrimination* and *Role ambiguity*). If not due to workplace stigma, participants in the peer focus group wondered if they were excluded from training opportunities because they were designed for clinical workers. Participants felt that training would still be relevant for peers and called for equitable access to PD and skill development for workers in designated LLE roles to progress in their careers (if they choose to).

11. Development of LLE Career pathways (supports recommendation 5)

Development of career pathways for workers in designated LLE roles should also be considered to progress the LLE workforce and provide opportunities for increased training and qualifications for career advancement and impact.[42,47] As noted earlier, given the current system necessitates acquiring qualifications in order to advance career, obstacles and opportunities for further training and qualifications for workers with LLE need to be identified in the WA alcohol and other drug context.

Further work beyond the scope of this project is required to explore this issue and could entail bringing together key stakeholders to develop a solution. Existing career advancement frameworks that may be a starting point include the 2021 WA MHC LE (Peer) Framework's "Lived Experience (Peer) career pathways and professional development workforces" as one strategy for organisations to demonstrate their commitment to the value of LLE.[42] QLD Health have developed a career pathway for workers in designated LLE roles to progress, ranging from a Peer Assistant/Trainee role up to a Director (LE Workforce) role (Figure 1).[47] This pathway also differentiates between personal

and career/family LE.[47] As noted prior, to avoid tokenism, career pathways should be considered in the context of creating roles with specific intention, with "real-world" impact.[49,58]

In QH, a career pathway has been developed for the Lived Experience (Peer) workforce to enable progression from an AO2 – AO8 level. This is shown in table 5 below.

Role descriptions have been developed for all Lived Experience (Peer) worker roles (Appendix 1). These outline recommended direct accountabilities specific to each role.

Table 5: Lived Experience (Peer) Workforce Career Pathway

Lived Experience (Peer) Workforce Career Pathway	
Director (Lived Experience Workforce) AO8	
Deputy Director (Lived Experience workforce) **AO7**	
Team Leader - (Lived Experience Workforce) **AO6**	
Lived Experience (Peer) stream	**Lived Experience (Peer) Carer stream**
Senior Peer Coordinator AO5	Senior Carer Peer Coordinator AO5
Advanced Peer Worker AO4	Advanced Carer Peer Worker AO4
Peer Worker AO3	Carer Peer Worker AO3
Peer Assistant/trainee (Peer/Carer) AO2	

Figure 1. Lived Experience (Peer) Workforce Career Pathway. From "Table 5: Lived Experience (Peer) Workforce Career Pathway", by the State of Queensland (Queensland Health), 2023. https://www.health.qld.gov.au/__data/assets/pdf_file/0039/929667/peer-workforce-support-framework.pdf.

Further Potential Mechanisms to Enable LLE Leadership

Recommendation six focused on embedding LLE systemically and safely. This section outlines potential ways to achieve this outcome.

Structural changes that embed LLE in alcohol and other drug and mental health systems in response to hierarchal inequities for people with LLE are needed, as identified in the literature and focus group discussions. These models and processes should be considered, explored and tested further with alcohol and other drug stakeholders. These include increased (purposeful) creation of senior leadership roles, increasing LLE leadership in existing decision making bodies, sharing leadership horizontally between LLE and professional/academic knowledge, creating LLE roles at every level of a system to increase power and influence, implementing a process enabling dynamic, fluid advisory groups of LLE experts and alcohol and other drug professionals collated by issue or project (with a LLE leadership 'connector'/coordinator role), ensuring that LLE representation is abundant and diverse in order to reflect the broad range of LLE, and alternate models (financial and electoral).

"To ensure safety, you can't engage a person; you need to engage a system."

"It's a system that makes this happen, not just a small group of people."

Models prioritising participatory processes and the embedment of LLE roles increase LLE power and leadership in decision making and hold great potential for overcoming ongoing challenges for the alcohol and other drug LLE workforce such as stigma and promoting safety.[43] Such structural

changes are also suggested in the mental health literature (see *Strategies to enable LLE leadership in mental health*). While currently alcohol and other drug workforce model prioritises professional knowledge, a participatory model equally values LLE participation.[43,44] Traditional models favouring professional knowledge have steeper hierarchies and may prevent communication within organisations,[64] limiting LLE power in decision making.[43] Flatter hierarchies hold greater shared power[64] and ensure LLE meaningful systematic input and leadership.[43]

A shift away from tokenism and towards greater LLE participation and leadership in governance can be seen broadly within behavioural health treatment services in the US with people with LLE involved across the sector within service delivery, research processes, and the development of policy and care models.[16] Recommendations around structural changes centring increased LLE embedment in alcohol and other drug and mental health systems in response to hierarchal inequities for people with LLE are apparent in the literature, as previously described. These include;

- increased (purposeful) creation of senior leadership roles, increasing LLE leadership in existing decision-making bodies
- sharing leadership horizontally between LLE and professional/academic knowledge
- creating LLE roles at every level of a system to increase power and influence
- ensuring that LLE representation is abundant and diverse in order to reflect the broad range of LLE, and alternate models (financial and electoral)[3,16,32,40,42,43,44,58,59]

Barriers for increased alcohol and other drug LLE participation and leadership include existing policies, lack of resources and resistance within the professional workforce to lose expert status.[45,46]As such, effective LLE participation requires strong managerial commitment and designated resources reflecting this.[40]

Embedding LLE may involve the creation of senior leadership roles within national policy bodies and state health and human services departments that have decision-making authority and control over budget resources.[3,43] At the service level, this might look like incorporating LLE leaders in roles such as board members, directors, and managers (more common in the USA than in Australia).[42,43] LLE leadership with horizontal power structures might involve shared leadership roles and comprehensive consultation.[43]

Peer and leader focus group participants suggested embedding LLE systemically should involve incorporating LLE roles at every level of governance and within all decision-making processes and bodies (policy and planning, implementation & evaluation, etc). This aligns with the literature recommending participatory processes being embedded systemically to ensure meaningful participation and to avoid tokenism.[32,44,58] Participants in the leaders focus group emphasised that *both* alcohol and other drug professional expertise and LLE representatives were needed at every level of governance to effectively guide the sector. Selection processes for LLE positions should involve a diverse panel (including alcohol and other drug panel members). As discussed in all focus groups, one individual cannot represent all alcohol and other drug LLE in a given setting, and to avoid tokenism and ensure effective LLE leadership, emphasis should be placed on incorporating many people from diverse backgrounds across different drug use, personal and family LLE, and regional and metropolitan areas.[40,42]

Participants in all focus groups also flagged that the alternative of one person in an alcohol and other drug LLE role in a mental health setting is not a safe option. Peer participants also commented that in the scenario of many embedded roles, having open communication pathways across levels between all the LLE roles would be crucial to ensure cohesion and safety. Participants in the peer and consumer focus groups noted that individuals in these roles also needed access and ongoing relationships with the vast range of alcohol and other drug communities, to represent the alcohol and other drug community effectively.

Importantly, participants across all focus groups felt that LLE roles must differentiate between alcohol and other drug LLE roles and mental health LLE roles, as alcohol and other drug LLE, already containing a diverse range of LLE on its own, needs its own distinct voice to represent alcohol and other drug specific concerns. Training and support would also be needed for individuals in these labelled LLE roles, with participants in the leaders focus group noting that training content, and who would be responsible for training delivery, need to be carefully considered. One final consideration was that people in these LLE roles should not be pigeon-holed into the role, and this should be accompanied by strategies to sustain and progress their careers.

Building on this idea, both the consumer and leader focus groups discussed the possibility of organising advisory groups as needed, per project or issue. An effective system needs to be dynamic, fluid and issue-dependant, as opposed to a set group of people responding to all issues and projects. Such groups would be comprised of both professional and LLE experts with expertise related to the topic, as well as other stakeholders related to the topic. In this process, there is a need for LLE leadership in a connector/coordinator role capacity, who can safely access and bring together the best representatives for the topic of focus.

Relevant existing organisations, such as PBHR, alcohol and other drug service sector Peer workers, AODCCC and WANADA, could also be utilised to provide access to a network of people with LLE relevant to the topic. The consumer focus group emphasised the significance of being able to represent themselves, and as such, ensuring representatives were members of the local community related to the topic, and elected by said community, was crucial.

"I wouldn't want to speak on behalf of meth users, but I wouldn't want others to speak on behalf of my [different] substance use"

The consumer focus group also reflected that they would feel more confident and safer to speak in such a setting knowing that other drug users were present, due to a feeling of shared vulnerability. In contrast, sharing in a much larger mixed group was not as easy due to feeling isolated. Other concerns around safety and negative consequences for participating in such a setting were highlighted by the consumer focus group, including health and travel repercussions, the risk of not being treated with respect and listened to, and a general distrust of medical professionals due to negative past experiences.

"You don't want to feel like you're in a zoo – "Look at these drug addicts putting together some policy, haha!" – Want to actually be respected, and have my contributions or opinions respected."

Measures to ensure safety and facilitate trust in such a setting were discussed by the consumer focus group, including attending with another (known) community member, having a leader

confident in making the space safe, opening the meeting with a commitment to a safe space free of prejudice, not being spoken over, and the autonomy to choose what extent of contact details are given. Inclusion and engagement of LLE in leadership requires trust and must be supported by a safe environment. The consumer focus group also noted that proper renumeration for participation in such a setting, as opposed to gift cards, was crucial in order to feel respected and valued.

The leaders focus group also observed the importance of good support processes in place for these settings, including supervision, critical reflection, and debrief. Having a continuous quality assurance process to reflect and ensure the process or dynamic 'council' body is working well and having impact was also suggested. As a final note, this dynamic process of bringing together both LLE and professional expertise as per issue, reflects the approach and way of working within the alcohol and other drug sector for many years, and is respectful to the large proportion of the workforce who have LLE.

Other models proposed in the mental health LLE literature that enable increased decision-making power for people with LLE include financial models, driven by consumer leader approval controls, and electoral models, where board members for an organisation are elected every 3 years by people with LLE.[59] The suitability of these models may also be considered in the alcohol and other drug context.

In the current Australian context, VAADA has partnered with SHARC and Harm Reduction Victoria (HRV) and is currently developing a LLE strategy to drive mental health and alcohol and other drug sector reform based on a model that centres on LLE and LLE leadership.[46] The goal is for LLE workforces and leadership to be embedded system wide, with oversight of services, and increased involvement in decision-making pertaining to design, delivery and evaluation.[46] The strategy will aim to create and support the growth of designated LLE roles including peer support roles, LLE managerial and leadership roles, LLE consultants and other policy and systems roles, and LLE educators, academics and researchers.[46]

At a services level, APSU (SHARC) have created a model for how to incorporate LE.[40] The model involves an audit of all current and previous consumer participation efforts, educating staff, improving existing consumer participation activities, creating, evaluating and recording new activities, and recruiting and training interested staff and service users.[40] The Network of Alcohol and other Drug Agencies (NADA) also have a consumer patriation audit tool for organisations to assess the extent of consumer participation in service delivery, program and policy development, equity and access, and capacity building. APSU (SHARC) emphasise ensuring organisations are well prepared for consumer participation, focusing on assessment of organisational culture towards consumer participation, and ensuring a safe and supportive environment for consumers to meaningfully engage in.[40] APSU (SHARC) also offer consumer participation training for professionals, delivered by consumers, concentrating on the effective development of consumer participation activities.[40] In addition, acknowledging the growth of people with LE participating in committees as consumer representatives, APSU (SHARC) note the need for terms of reference to reinforce the equality of all participants, and to reimburse participants for their time.[40]

Finally, although systemic reform and increased consumer participation processes promote intentional avenues for the voice of people and leaders with LLE to have more say within sector governance and stewardship, it cannot be forgotten that in the alcohol and other drug sector, much

of the LE knowledge remains hidden and choice and anonymity around disclosure is and should remain personal.[41]

Within WA, participation of alcohol and other drug workers, service users and consumers in the planning and relevant policy development across all sector and systems is supported.[12] The suggested models promoting alcohol and other drug LLE embedment and leadership, and tools developed for increased consumer participation processes, should be carefully considered.

Conclusion

Individuals with LLE have a long history of involvement in the alcohol and other drug sector, with about two-thirds of the Western Australian alcohol and other drug workforce reporting LLE at present. However, the existing literature on LLE in the alcohol and other drug workforce is limited, partly due to non-disclosure. Non-disclosure may stem from a general persisting culture of stigma towards alcohol and other drug use and/or a desire for privacy in one's professional life and perceived relevance. The overlap of LLE between designated LLE (peer) and non-designated LLE (professional) roles indicates that LLE may impact practice even outside designated positions.

Roles that are LLE designated are largely entry-level positions, and there are limited opportunities for career advancement and few leadership roles. Career advancement within the current system in generally requires further training and qualifications, so obstacles and opportunities need to be identified, and solutions for meaningful career pathways further explored in consultation with key stakeholders. There is a growing interest in LLE leadership positions, with these roles beginning to increase due to the broader movement of incorporating LLE in mental health and other fields. The alcohol and other drug sector needs a unique approach to LLE from other sectors, that recognises the context of LLE being involved since the inception of the field. This requires time and further consultation with the sector to develop universally accepted terminology and the development of dynamic processes to bring together both LLE and professional knowledge in sector governance in a way that is meaningful, impactful and avoids tokenism.

In summary, tackling the challenges confronting the LLE workforce and the obstacles to LLE leadership in the alcohol and other drug sector, and effectively, supporting ways of working with people, leaders and experts with alcohol and other drug LLE, requires a comprehensive approach that includes cultural change, clear roles and support, and systemic reforms while acknowledging the broad range of experiences of LLE individuals and prioritising their safety. By integrating LLE expertise alongside professional expertise, the sector can increase meaningful impact, improve service delivery, and foster a more inclusive, safe, and equitable environment for all stakeholders in the alcohol and other drug sector.

"To ensure safety, you can't engage a person; you need to engage a system."

- WA focus group participant

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Appendix

Appendix A: Challenges, Barriers & Solutions

The challenges faced by the LLE workforce in the alcohol and other drug sector, barriers to LLE alcohol and other drug leadership and potential solutions have been explored in detail throughout the report. Drawing on the limited academic and grey literature available, and the stakeholder focus group discussions, this summary brings the challenges, barriers and potential solutions together.

Challenges Faced by LLE Workers

1. **Stigma and discrimination:** Stigma towards alcohol and other drug use and its harmful impacts are arguably perpetuated in broader society through systemic issues such as the continued criminalisation of drug use and enforcement-driven policies, and this persists within the health system and the alcohol and other drug sector. Stigma and discrimination from (some) professionals without LLE towards workers who disclose alcohol and other drug LLE is present in the WA alcohol and other drug sector. This is further compounded for workers in designated LLE roles who are discriminated against due to their position being based on experience rather than formal qualifications, and a lack of professional understanding of the value of LLE work. This contributes to a lack of safety and workplace trust, and feelings of being undervalued and disempowered. Lack of a supportive work environment and workplace trust are compounded by concerns around job security for LLE roles conditional on LLE status, which is incompatible with the non-linear nature of recovery.
2. **Role ambiguity:** The lack of clear role definitions for LLE positions reflects and perpetuates poor professional understanding of what LLE workforces do, leads to conflicting expectations and contributes to feelings of frustration and being undervalued among workers.
3. **Inadequate training and support:** Role ambiguity is compounded by inadequate training and support, contributing further to poor understanding and perceived legitimacy of LLE roles, and making it challenging for workers in designated roles to balance the emotional laborious duties such roles require by nature.
4. **Limited career advancement:** The current system in general requires further training and qualifications for alcohol and other drug designated LLE roles to advance career. Poor understanding of LLE roles and the perception that LLE roles are less credible than traditional clinical roles may contribute to gatekeeping and restricted access to advancement opportunities, again highlighting the importance of addressing root issues of stigma and discrimination and role ambiguity.

Barriers to LLE Leadership

1. **Cultural Resistance:** There exists a broader sociocultural norm that favours formal education over experiential knowledge and this extends to the alcohol and other drug sector and broader health system, hindering the acceptance of LLE in leadership roles. This is further compounded by issues of stigma and discrimination, role ambiguity, and a lack of training contributing to poor understanding and legitimacy of designated LLE roles.

2. **Limited Data:** The scarcity of data regarding LLE workers in the alcohol and other drug sector hampers efforts to understand and develop this workforce, and contribute to a lack of understanding and acceptance of LLE work by the broader workforce.
3. **Lack of career progression pathways:** Most alcohol and other drug designated LLE roles are entry level, with few leadership roles available and unclear career progression pathways. The current system in general requires further training and qualifications to advance career, therefore obstacles and opportunities for progression and leadership need to be identified, and solutions for safe and meaningful career pathways further explored in consultation with key stakeholders.
4. **Risk of tokenistic and unsafe representation:** Increasing LLE leadership in the alcohol and other drug sector may not have a simple solution. The practice of appointing a single or few alcohol and other drug LLE representative/s across various committees may not work in the unique alcohol and other drug context where LLE is extremely diverse and concerns around trust and safety are paramount due to the high stigmatisation of alcohol and other drug use and its harmful effects.

Potential Solutions

1. **Labelling and Terminology:** Exploring alternative terms for LLE that may have greater acceptability in the alcohol and other drug context is important to reflect the unique, long history of LLE in the alcohol and other drug sector. Negotiating role titles to reflect duties rather than LLE status and providing individuals with the choice to adopt or not adopt LLE (or other related labels) in their role titles may be more empowering than a lack of choice or forced adoption of the LLE label and could help mitigate concerns individuals in designated LLE roles have around stigma and negative impact on career progression.
2. **Role Clarity and Professional Development:** Establishing clear role definitions for LLE positions and ensuring access to adequate training, supervision and professional development can help legitimise LLE work and foster a supportive environment.
3. **Supportive Workplace Cultures:** Cultivating a systems and sector culture that values and respects LLE requires clearly demonstrated managerial support, supportive policy addressing stigma, and education for non-LLE staff about the contributions of LLE workers and how to work with them.
4. **Creating Leadership Pathways:** Developing structured career development pathways for LLE workers that recognise and elevate their contributions will increase LLE leadership, thereby increasing LLE visibility and influence within the sector.
5. **Systemic Change:** Embracing structural changes within the system and sector—such as embedding LLE roles throughout the system and sector and moving towards more democratic leadership models—can enhance LLE representation, acceptance and decision-making power, fostering LLE leadership and a more inclusive environment. Dynamic processes bringing together both LLE and professional knowledge should be further explored with alcohol and other drug stakeholders. Conversely, hiring one or few single alcohol and other drug LLE representative/s to speak for the diversity of LLE in alcohol and other drug across a range of

committees or projects is not supported in the literature or by WA stakeholders and risks tokenism and limited meaningful impact.

Appendix B: Key Findings

The Key Findings represent a critical analysis of the literature review and focus groups discussions, embedded within relevant sections of the report. The following is a list of Key Findings for ease of reference.

Key Finding 1: There is a long history of LLE in the alcohol and other drug workforce. The literature on the Australian alcohol and other drug workforce and LLE is limited. Approximately two thirds of the WA alcohol and other drug workforce report having LE. The boundary between the peer and professional workforce may be less distinct than expected. This suggests LLE, albeit undisclosed and unacknowledged, could influence practice in non-designated LLE roles in the alcohol and other drug sector.

Key Finding 2: Many alcohol and other drug workers do not disclose their LLE, due to concerns around stigma & discrimination, and/or because of lack of perceived relevance to their current role.

Key Finding 3: Individuals with personal LE are more likely than individuals with family/other LE to cite stigma and judgement or confidentiality as reasons against disclosure.

Key Finding 4: There is a general lack of data on alcohol and other drug workforce characteristics, including the alcohol and other drug LE workforce.

Key Finding 5: Majority of alcohol and other drug workers with LLE are not in designated LLE roles.

Key Finding 6: Peer work is the most well-established and documented designated LLE role in the alcohol and other drug sector, employed across a broad spectrum of roles encompassing outreach and prevention, harm-reduction services, and treatment and crisis response.

Key Finding 7: Positive outcomes of peer intervention include reduced alcohol and other drug related harms for service users, improvements in recovery outcomes and relapse rates, increased reach of harm reduction programs, increased treatment retention, and increased client confidence and trust in services and support.

Key Finding 8: Designated LLE or LE required roles are not limited to peer worker roles and can include alcohol and other drug project officers, representatives within advisory committees, boards of directors and other governance bodies, consultants, educators and advocates, and peer researchers.

Key Finding 9: Limited data and the observation that two thirds of the alcohol and other drug workforce report LE suggest that types of roles and role specifications are similarly distributed between workers with and without LE, but further research in the Australian and WA context is needed to explore this.

Key Finding 10: Given the limited visibility and extent of LE among alcohol and other drug workers, workplace support initiatives for workers with LE must be accessible by all workers or executed in a way to preserve anonymity and autonomy.

Key Finding 11: Limited data suggest Australian alcohol and other drug workers with LE are not at higher risk of burnout than those without LE, however high risk of burnout is considered a challenge for alcohol and other drug workers with LE in other.

Key Finding 12: Limited data in the WA context suggests workplace support measures are in place, but the extent to which this is accessible/accessed in practice, and that which is perceived as the most beneficial by workers with LLE are missing from the literature.

Key Finding 13: Stigma and discrimination towards alcohol and other drug workers with LLE persists within the sector globally and within WA, demonstrated by internal hierarchies within services and organisations between designated LLE and non-LLE workers. LLE is not accepted or respected by alcohol and other drug professionals in the same way clinical knowledge is, reflecting the broader cultural norm of valuing formal education over other forms of knowledge, and the external stigmatisation of the alcohol and other drug sector as whole in.

Key Finding 14: Workers with LLE experience conditional trust issues in the workplace and fears around job security if they disclose that their alcohol and other drug use status has changed within their workplace. This is not conducive to a safe and supportive work environment given the non-linear nature of the recovery journey.

Key Finding 15: Pay and employee benefits inequities between workers in designated LE roles and workers without LE exist in other settings, but there is a lack of data available to explore this in the WA context.

Key Finding 16: Role ambiguity for designated LLE roles is a prominent issue and reflects poor professional understanding of what LLE workforces do. This leads to conflicting workplace expectations, unneeded worker pressure and frustration, and feelings of being undervalued by non-LLE staff.

Key Finding 17: Peer and LE workers undertake emotionally laborious roles requiring a skilful balance between purposeful sharing of personal experience, maintaining professional boundaries, and managing personal triggers and risk of relapse. Despite this, lack of adequate training and support is recognised in the literature as a challenge for LE workers. There are no data in the literature of the extent of this issue in the precise WA alcohol and other drug LLE context, but participants in the peer focus group expressed that there was a need for equitable access to PD and skill development.

Key Finding 18: While LLE role labelling may enable career opportunities despite not having formal academic qualifications, the label may stifle career progression within both the alcohol and other drug sector and externally.

Key Finding 19: A lack of opportunities for career progression is a challenge for the alcohol and other drug LLE workforce. Barriers to career advancement opportunities for workers with LE may partly be due to a lack of understanding and acceptance of what LE workers do, stigma, and resulted clinician gatekeeping.

Key Finding 20: Concerns around job security for workers in LLE roles arise due to an individual's LE becoming more dated, the conditional nature of some LLE roles, and concerns around stigma preventing individuals from changing career paths outside of alcohol and other drug LLE.

Key Finding 21: Very limited literature on leadership within the alcohol and other drug LLE workforce context and a broader sociocultural framework of valuing formal education over experiential knowledge contribute to limited LLE leadership. Challenges faced by the alcohol and

other drug LLE workforce more generally, such as stigma and discrimination, role ambiguity, a lack of adequate training and workplace support, and limited career advancement options also do not foster a sense of feeling respected, valued, safe and empowered, from which leadership can develop. Addressing these is deemed necessary to facilitate a safe and supportive foundation for leadership. Further, systemic changes may foster greater alcohol and other drug LLE leadership.

Key Finding 22: LLE work in the alcohol and other drug sector has existed since the inception of the field. Incorporating LLE workers into mental health services is a more contemporary movement. As such, there is discomfort using the term "LE/LLE" in an alcohol and other drug context. LLE is the preferred term over LE, acknowledging that the recovery journey is not static.

Key Finding 23: Despite the apparent longer history of LLE leadership roles in the alcohol and other drug sector**,** mental health LLE workers face similar challenges as LLE workers in alcohol and other drug including stigma and discrimination, role ambiguity, lack of understanding, respect and valuing of LLE roles by clinicians, and lack of suitable training and support.

Key Finding 24: The status of LLE leadership in mental health in Australia, although expanding, remains limited, and may reflect traditional reservations and associated stigma about LLE leadership. LLE roles primarily occupy entry-level positions and face significant barriers to career advancement, which have also been described for alcohol and other drug LLE.

Key Finding 25: Hiring one single person to represent the diversity of LLE in mental health across a range of committees or projects to meet accreditation standards is tokenistic. This sentiment is also echoed in the alcohol and other drug sector. However, creating executive-level LLE roles may have a positive influence in fostering LLE worker acceptability and growth of the LLE workforce if the role is created with set intentions and purpose, supported with adequate support measures and training, and is able to impart 'real-world' impact. This is worth consideration as a mechanism to increase LLE in the alcohol and other drug workforce in WA.

Key Finding 26: Strategies in response to key challenges for the mental health workforce, such as stigma and role ambiguity, are similar to those reported in the alcohol and other drug literature. These include adequate support, supervision and training for LLE workers, clear roles, education and training for staff without LLE or LLE work, and demonstrated managerial support of LLE workforces, cultivating positive and safe workplace cultures.

Key Finding 27: Lack of professionalisation of the mental health and alcohol and other drug LLE workforces results in disparity in the readiness of LLE workers and contributes to lack of perceived credibility by non-LLE workers. While professionalisation may elevate credibility in the system for both mental health and alcohol and other drug LLE workforces, standardising the LLE profession carries the risk of diluting the nature of peer work.

Key Finding 28: Structural systemic changes are proposed in the mental health literature as a means to enable mental health LLE leadership. These include creation of leadership career pathways utilising existing activities undertaken by LLE workers such as advocacy and education, increased embedment of LLE roles, and restructuring of traditional medical hierarchy towards more democratic and horizontal power structures.

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