ALCOHOL AND OTHER DRUG (AOD) **LIVED EXPERIENCE WORKFORCE** DISCIPLINE FRAMEWORK

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

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

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

VICTORIA State Government

Published by

sharc
Self Help Addiction Resource Centre

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The Victorian AOD Peer Workforce Community of Practice.

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ACKNOWLEDGEMENT OF COUNTRY

The Alcohol and Other Drug Lived Experience community acknowledges Victoria's Aboriginal and Torres Strait Islander communities as the First Peoples and Traditional Owners and custodians of the land and water on which we live, work and play. We acknowledge that sovereignty has never been ceded – it always was and always will be Aboriginal land.

We acknowledge that colonial structures and policies remain in place today and recognise the ongoing struggles of First Nations people in dismantling those structures. We know that cultural safety and capability is everyone's business, including the business of lived experience workforces and communities.

We express our deepest appreciation to the First Nations peoples for their generosity of time, knowledge sharing, expertise and support in the development of Victoria's lived and living experience communities. We are grateful for their resilience, wisdom and relentless pursuit of justice, as they inspire us to work together towards positive change. Our community has so much to learn from First Nations and we are committed to developing pathways and partnerships to support this.

As a community we embrace self-determination and reconciliation and look forward to fostering meaningful partnerships, cultural sensitivity and Aboriginal self-determination in our approach to lived experience work.

A note on Aboriginal and Torres Strait Islander lived experience

This framework does not reflect Aboriginal and Torres Strait Islander lived experience. Aboriginal and Torres Strait Islander people have their own ways of understanding lived experience. Aspects of cultural identity, collective experience and lived experience of trauma, distress and service use inform how the experience is understood and expressed.[1]

This lived and living experience is complex and based within a history of colonisation, intergenerational trauma, spirituality, cultural practices and protocols. Lived Experience workers from the Aboriginal and Torres Strait Islander communities align with culturally inclusive and culturally led responses based on a social and emotional wellbeing framework.[2]

CONTRIBUTORS

The development of this framework was made possible by the Lived and Living Experience Workforce Development Project 2022-2024 funded by the Mental Health and Wellbeing Division of the Department of Health, Victoria. This project was commissioned in recognition of the value of lived and living experience workforces across sectors and supports a robust suite of workforce development initiatives to ensure these workforces are supported and continue to thrive.

This framework has been developed in collaboration with numerous stakeholders and in consultation with the Victorian Alcohol and Other Drug Peer Workforce Community of Practice , Peer Projects and the Association of Participating Service Users of the Self Help Addiction Resource Centre (SHARC) , Harm Reduction Victoria, Alcohol and Other Drug Lived Experience workforces across Victoria and our allies with lived and living experience in the Victorian mental health and wellbeing sector.

GLOSSARY

Alcohol and Other Drug (AOD) sector: A collective term for all AOD services funded by the Victorian government, including prevention, early intervention, harm reduction, treatment and ongoing support programs.[3] This includes AOD services available to all Victorians, targeted services such as Aboriginal and youth services and AOD services provided to people in the community as part of a court order.

Advisors: Advisors in organisations, councils and government draw on the considerable body of collective AOD service user knowledge to inform systemic change and bring about change to laws, policy, procedures and bureaucracy that cause or perpetuate injustice or inequity.

Consultants: Consultants at organisational and policy levels, providing systemic advice and support to services and individual advice to people accessing services. The focus of consultant work is service improvement through the service user perspective, with particular attention to practices, policies and procedures that affect access and equity.[4]

Consumer Participant: A consumer participant is an individual who contributes to service design and delivery, policy development, governance etc. Consumer participants differ from AOD LEW in that they utilise their lived experience exclusively from their perspective as a service user, which differs from the integrated lived expertise and formalised training that is required of AOD LEW to fulfill the requirements of their roles.

Co-occurring needs: Describes a range of different support needs a person may experience at the same time. Generally, this refers to people who experience co-occurring mental illness (including people experiencing suicidal thoughts and behaviours) and substance use or addiction, with or without a formal diagnosis.[5]

Designated and non-designated roles: The term 'designated' indicates a role in which lived and living experience is an essential requirement, in addition to relevant training, skills and knowledge.[6] 'Non-designated' indicates a role that does not require lived experience. Designated roles include all positions that require lived and living experience as key criteria, regardless of position type or setting.

Educators: Educators work in partnership with others to co-produce and co-facilitate educational programs through the service user perspective, knowledge and experiences to assist with learnings.

Family: Those with a significant personal relationship with a service user including biological relatives and non-biological relatives, intimate partners, ex-partners, people in co-habitation, friends, those with kinship responsibilities and others who play a significant role in the service user's life.[7] Some family members may identify as a 'carer' in a service user's life, while others identify with the characteristic of their relationship (e.g. parent, child, partner, sibling).[8] 'Family' in this framework refers to family of origin and family of choice and the range of relationships, social connections and supports that many people have in their lives.

Family AOD lived and living experience workers: A collective term for workers who draw on their life-changing experiences to support and advocate for people impacted by substance use and/or addiction through a family perspective, minimising experiences of isolation, stigmatisation and marginalisation.

Harm reduction: Harm reduction refers to policies, programs and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws. It focuses on positive change and on working with people without judgement, coercion, discrimination or requiring that people stop using drugs as a precondition of support. Harm reduction empowers people to reduce the harms associated with substance use, without necessarily requiring a reduction in use. Harm reduction strategies support safer decision making about the use of substances, modify risk factors that can lead to AOD-related harm and contribute to better health and wellbeing outcomes for individuals and the community.

Harm reduction peer workers: People with lived and living experience of substance use and overdose risk who are employed in harm reduction roles that promote the health and wellbeing of people who use drugs.

Leadership roles: In line with the values and principles of the lived experience community, managers, project leads, coordinators and team leaders are experienced lived experience workers who deliver programs and services and may support and develop other lived experience workers.

Living experience: Someone who identifies as having ongoing experience of substance use. It can apply to current substance use and/or related harms, to families whose experiences of supporting someone with substance use or addiction are ongoing and for those who choose to employ this term to reduce stigma associated with substance use and addiction.

Mental illness: Refers to a medical condition characterised by a significant disturbance of thought, mood, perception or memory, as defined in the *Mental Health and Wellbeing Bill 2022 (Vic)*.[9]

Participation: The process of involving service users and families in decision making about service planning, policy development, priority setting and quality in the delivery of services. Participation is based on the belief that those who are affected by a decision have a right to be involved in the decision-making process.

Peer: An individual with a connection to a specific community which acknowledges them as a peer.

Peer workers: Peer work focuses on building relationships where self-determined healing is supported through identification, mutuality and connection. Peer workers play a key role in reducing stigma, increasing person-centred care and bridging the gap between services and service users. Peer workers walk alongside service users, providing information and advocacy and strengthen services through sharing service user perspectives.

Recovery: With no universal definition, the concept of recovery is a self-defined process of meaningful life change, which doesn't always mean abstinence from substance use. We collectively identify with this description: 'the essence of recovery is a lived experience of improved life quality and a sense of empowerment… the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration.'[10]

Recovery capital: For those impacted by AOD use, concepts of 'recovery' have moved from abstinence to being 'a process rather than an end state, with the goal being an ongoing quest for a better life'.[11] With recovery conceptualised as a process in this way, AOD LE workers are pivotal in the increase of 'recovery capital' which refers to the sum of resources that may facilitate the process.[12] An increase in recovery capital is born from connection, the foundation to all peer-to-peer relationships. Supported by identification, AOD peer workers connect through a system of giving and receiving help founded on key principles of respect, shared responsibility and mutual agreement of what is helpful.[13] This similarity and reciprocity[14,15] is what we know today to be the essence of AOD peer support and is complemented by the principles and tasks of Intentional Peer Support.

Service user: A service user is someone who uses, has used or is eligible to use AOD services. It includes people who are refused services or who refuse services. It also includes family and supporters of people who use services, regardless of whether they directly use these services. People affected by AOD policy and laws are also considered service users. Service users may also be known or referred to as consumers.

Substance use and addiction: Substance use refers to the use of alcohol or other drugs. In some cases, substance use can become harmful and negatively impact someone's life and/or that of their family. Some identify having a lack of agency in using substances and some identify as having agency, with their substance use a choice and right. Addiction is a medical term used to describe a condition where someone continues to engage in a behaviour despite experiencing negative consequences[16]. It can also be described as substance dependence.

A note on language

SHARC recognises the power of language, that words can have different meanings to different people, that language preferences differ across communities and that our experiences are personally defined. To inform the language used in this framework we have consulted with our rich and diverse AOD lived experience community and largely aligned with the language outlined in *The Power of Words: Having alcohol and other drug conversations – A practical guide*[17] and preferred terms adopted by the *Royal Commission into Victoria's Mental Health System Final Report*.[18]

The term AOD LEW is an umbrella term for both direct and indirect roles across systems.

INTRODUCTION

Every profession needs a structure to support it, strengthen it and guide its development. In most cases, this structure is known as a discipline framework and is made up of all the elements required to understand the discipline.

The AOD Lived Experience Workforce Discipline Framework (Victoria) (the Framework) has been developed as an informative document describing the Victorian AOD LEW history, values, skills, knowledge base and scope of practice.

The Framework details the elements of the AOD LEW discipline and is intended for the current and emerging AOD LEW, AOD and allied sectors and stakeholders to:

- Increase knowledge of the Victorian AOD LEW.
- Provide a foundational understanding of the AOD LEW knowledge base, skills and scope of practice.
- Provide guidance to people working with the AOD LEW or seeking to employ AOD Lived Experience workers.
- Support the ongoing development of the AOD LEW.[19]

The Framework has been developed in response to the Royal Commission into Victoria's Mental Health System (the Royal Commission).[20] The Royal Commission's vision was for system transformation with lived and living experience at the centre. Realising this vision necessitates establishing strong foundational structures for the Victorian lived and living experience workforces (LLEWs) where they are recognised, understood and valued, with the support structures afforded to any other profession.

This Framework forms part of these foundations, delivering on recommendations from the Our Future report.[21] It has been developed in recognition of the champions who have tirelessly advocated for the discipline and of the state government's investment in workforce development that acknowledges the invaluable contribution of all LLEWs.

What is Alcohol and Other Drug Lived Experience

The term 'lived experience' has long been used in social justice movements to describe the direct, first-hand experiences of people from marginalised communities. While there is no universal definition, as experiences are personally defined, lived experience of substance use and/or addiction refers to an experience that radically changes a person's life and influences how they see the world. It can include exposure to marginalisation, stigmatisation, criminalisation and adversity. For many, this experience includes a self-determined healing journey with its own associated challenges and opportunities.

AOD Lived Experience work is being willing and able to share and apply the knowledge and understanding gained through lived experience. It is both the particular lived experience that is important to the work and – critically – it is the expertise, knowledge, skills and wisdom gained through this experience.

Our history

The lived experience movement in Victoria has evolved over a number of years and now serves as a crucial part of Victoria's health, community and social service design and delivery. This history acknowledges the champions, leaders and lived and living experience communities who have played a part by bringing their voices and positions to the fore both in AOD and across systems.

The theoretical underpinnings of the AOD LEW are broad and come from a diversity of disciplines including public health, psychology and sociology. For example, a main theoretical driver of AOD peer work is that of the health-promoting effects of peer support.[23] Historically this is drawn from twelve step communities, the positive outcomes drawn from 'fellowship' and the unique value of 'one addict helping another.'[24, 25]

AOD Lived Experience work emerged in its earliest form in the 1930s from grassroots mutual self-help organisations such as Alcoholics Anonymous,[26] underpinned by peer support and reciprocal social, emotional and practical support. The recovery advocacy movement soon followed, represented by hundreds of recovery advocacy organisations and thousands of self-identified core recovery advocates.[27] In the 1960s, the evolution of AOD Lived Experience work also began in grassroots peer-led harm reduction responses, peer education initiatives and the rise of drug user organisations.[28, 29] In recent years, the formal advocacy and political organisation of recovery has occurred, led by the Faces and Voices of Recovery coalition.[30]

EXPERIENCES AND IMPACTS ARE VERY PERSONAL

It is important to understand that the experiences and impacts, are very personal and while 'how much experience is enough' is highly subjective, people with lived experience describe experiences that changed life as they knew it and took them on a different path from what they had planned. The experiences, particularly for people in personal Lived Experience roles also caused significant change to the way they viewed themselves and their place in the world.[22]

In the 1970s, an unmet need for treatment of AOD use-related issues led to the creation of a small number of therapeutic communities, established by people with lived experience who understood the power of self-help and peer support.[31] In Victoria, peer led organisations grew in the 1980s, including the Self Help and Substance Use (SHASU) Project, an umbrella organisation for drug self-help groups and the Understanding & Support (US) Society, founded by a group of individuals in AOD recovery to offer others empathic understanding and support in a substance-free and home-like environment.[32] People with AOD lived experience played prominent roles in the rise of the modern AOD sector, once making up nearly 70 per cent of the workforce,[33] and while there has been an increase in professionalisation over the years, lived experience still makes up over 40 per cent of the AOD workforce in Australia.[34] We honour the many people with lived experience but not in designated roles, recognising the challenges many faced. Now, we look to the future state of designated and intentional application of lived experience and expertise across the sector.

In this future state, it's important we continue to develop our understanding of the difference between service user engagement and professional lived experience, and the critical, but unique, value they bring to our sector at all levels.

In the late 1990s Victorian policy began to champion AOD consumer participation initiatives, and to support the rise in participatory approaches, the Association of Participating Service Users (APSU) was established in 2000.[35] Strategic direction for consumer participation activity has since been driven by APSU through government policy, advocacy, sector guidance and development of the first introductory training to AOD lived experience.[36]

Over the following years, consumer participation practice has evolved significantly and remains highly valued as an aid to improve health outcomes and the quality of health care, as an important democratic right and as an accountability mechanism.

While there were a number of designated AOD LEW roles by 2014, gaps remained and locally targeted efforts across Victoria worked towards building peer support activity.[37, 38]

Victorian AOD LEW development has been funded by the Department of Health since 2016, with workforce, lived and living experience led programs and peer-led initiatives becoming part of core service delivery across the system.[39] In 2018, Peer Projects, a program of SHARC, was established to act as the central resource for AOD LEW development supported by the 2019 Strategy for the Alcohol and Other Drug Peer Workforce in Victoria.[40]

In 2020, the Department of Health established the Lived Experience Workforce Advisory Group (LEWAG) to provide advice to government on reforms and workforce related initiatives. Further expansion of AOD LEW infrastructure occurred as part of Victoria's mental health system reforms including new AOD lived experience roles in the Department of Health and the establishment of the AOD Lived and Living Experience Advisory Group (AOD LLEAG) as a voice to government.

Who is the Victorian AOD Lived Experience worker?

The AOD LEW is comprised of workers who have:

- **Lived experience** – personal experience of substance use and/or addiction, either past or present, that radically changes their life and influences how they see the world.
- **Lived expertise** – the knowledge, wisdom and frameworks we intentionally apply in our work, arising from reflection on our direct lived and living experience of:
  - The impacts of alcohol or drug use, gambling and related issues on ourselves and/or our loved ones.
  - Society's responses to these issues, including our experiences of surviving stigma, discrimination and extreme marginalisation.
  - The effects of services and strategies that governments and other organisations put in place to address these issues.
  - For some of us, the process of changing our relationship to these issues.
- **Learned experience and expertise** – discipline specific training, ongoing professional development and practice expertise.

The AOD Lived Experience worker provides direct support – building relationships where self-determined healing is supported through identification, mutuality and connection; driving service and system improvement through the service user perspective, with particular attention to practices, policies and procedures that affect access and equity; and using their expertise in leadership, governance, education and research.[41]

The Victorian AOD Lived Experience worker performs a range of functions across various systems and settings. Roles and responsibilities vary from peer support to executive leadership; however, workers all draw on their life-changing experiences to humanise experiences of help, increase service accessibility and quality, working towards system transformation.

AOD LEW roles are those in which lived experience is an essential requirement in addition to lived expertise and relevant skills and knowledge.

Person to person roles

- Peer support workers, peer mentors, peer support group facilitators
- Work directly with people accessing services
- Peer work focuses on building relationships where self-determined healing is supported through identification, mutuality and connection.

Service and system-based roles

- AOD Lived Experience advisors, AOD Lived Experience consultants, peer educators, project workers, evaluators and researchers
- Use lived experience and skills as strategic partners in building services, policies, systems and evidence
- Includes leading continuous quality improvement initiatives that make services more accessible, responsive and effective for the people accessing them.

Governance, leadership and development roles

- Board positions, Committee and advisory, Executive, Directors, team leaders, managers, workforce development leads and lived experience supervisors
- May work directly with people accessing services as well as leading other lived experience workers
- Work within systems in services and on projects that change systems for the better, develop the workforce and service improvements.

VALUES AND PRINCIPLES

Our values are illustrative of who we are, what is important to us, and what underpins our work. They are born from passion, lived experience and lived expertise and provide a compass for the work we do today and the work of the AOD LEW in the future.

Core values

Lived expertise	The knowledge and insights gained from life changing experiences provide a unique and invaluable expertise that can transform services, systems and communities. People with lived experience are experts in their own lives and can use this expertise to support others on pathways to self-defined healing.
Empathy	Lived experience and lived expertise provide a pathway for relationships, where empathy, vulnerability and trust thrive. Grounded in identification and connection, empathy is the fundamental enabler in relationships – when we tap into empathy, we know we could very easily be in the same situation, if we haven't already. Empathy is a choice to experience vulnerability, a choice to connect with something inside ourselves in order to connect with another.
Community	The AOD LEW is part of a longstanding community movement. We are diverse but unified by shared goals. Our community fosters collaboration and co-learning to transform service user experiences of treatment, care and support. We are empowered by a sense of belonging, to grow individually, to empower each other and to influence positive change.
Participation	Service users have the right to participate in, partner and lead in decision making that affects them. Elevating participatory approaches requires acknowledgement of and action to remove systemic and structural challenges, promote inclusion and reduce stigmatisation and discrimination.
Mutuality	In relationships, we work from a basis of mutuality, minimising power imbalances, embracing opportunities for co-learning and encouraging self-determination. Our practice is strength based, underpinned by hope and recognition that each person can create a life meaningful for themselves. People we walk alongside are recognised as active agents, experts in their own right, with deep knowledge about their needs, rather than as passive recipients of others' expertise.
Equity	We advocate for an equitable society where everyone has the opportunity to thrive, free from stigma and discrimination. Equity is achievable through the elimination of stigma and discrimination and the transformation of systems, services, policies and laws required to attain this. Equity begins with accessible and service user informed and led service provision.
Integrity	Our practice is underpinned by integrity, strong adherence to values and ethical principles. Transparent, consistent and accountable, we are authentic in sharing our uniqueness, creating a safe place for others to share theirs. Honesty is our practice of courage, to speak truth in order to rewrite what hinders and harms.

SCOPE OF PRACTICE

LIVED EXPERIENCE ROLES

LE roles exist in diverse organisations and settings, spanning entry level to executive leadership roles. While it's true that everyone has some experiences of distress and adversity, not everyone has significant challenges that take their lives in an entirely new direction. Lived experience roles are primarily informed by life-changing challenges and experiences.[11]

The work of the AOD Lived Experience worker ranges from acute and community-based service provision across both public and private settings to policy advice, research, evaluation, management, leadership and governance. The work is not defined by what is done but by why and how it is done and by whom.

With lived expertise as their driving force, AOD Lived Experience workers:

- Offer one-on-one support, deliver groups and education in the AOD sector and across health, mental health and justice.
- Work in leadership positions in mainstream and peer led organisations.
- Lead teams of AOD Lived Experience consultants and peer workers.
- Contribute to service planning, helping policy makers decide what services should be available, where and to who.
- Sit on expert committees, governance and advisory groups to bring a specific focus to the needs of service users.
- Inform research priorities, design and perform research.
- Provide training and support and help build the LEW community.

No matter what their role is called or the function they carry out, the principle of their work is the same. While AOD LEW roles are wide ranging, like most LLEWs, it's not necessarily about what we do but why and how we do it.

In simple terms, AOD Lived Experience workers draw on their life-changing experiences to walk alongside others facing similar challenges, elevate the collective expertise of service users, work to improve services and transform systems.

Peer support

Support that is founded on identification and connection where mutual relationships provide a foundation for trust, empowerment and hope.

Informational support and individual advocacy

While primarily focused on empowering service users with information, this support includes the provision of specific information about services, systems and rights, supporting system navigation, or provision of direct advocacy for individual needs.

Participation and partnership

Through sharing their expertise, AOD Lived Experience workers can be seen as change agents who actively influence and contribute to effective service delivery through participation and partnership.

A key feature of the AOD LEW is the capability to increase knowledge of the service user experience in service design and development and in doing so improve the culture and quality of services and service user experiences of care.

Systemic advocacy

Advocacy at policy and service system levels delivered by AOD LE workers is often connected to the collective voice of other service users. They understand that individual experience is connected to system change, and have a drive to improve services and outcomes.

BELONGING TO THE COMMUNITY

Belonging to the AOD LEW community is not just about mutual support centred on personal challenges, it is also about gaining an empowering identity, being part of a movement, experiencing solidarity alongside others.[10]

CORE SKILLS AND KNOWLEDGE

For the AOD LEW to be effective, its workers require core knowledge.

This includes:

- **Lived experience** – personal experience of substance use and/or addiction, either past or present, that radically changes their life and influences how they see the world;[42] and
- **Lived expertise** – knowledge, perspectives, insights and understanding gathered through lived experience.

This foundation is enhanced through:

- **Discipline specific training** – formal training in AOD LEW practice and guidance on the intentional and purposeful use of lived experience coupled with training in competencies to work in formalised settings, e.g. Intentional Peer Support training supported by SHARC Peer Worker Training.
- **Targeted professional development** – training, both discipline-specific and mainstream that enables people in the AOD LEW to operate in certain environments and deliver on responsibilities, e.g., some senior and leadership roles require a certificate or degree level qualifications.
- **Discipline specific supports** – ongoing learning, regular discipline specific supervision and engagement with the broader AOD LEW community, e.g., Victorian AOD Peer Workforce Community of Practice.

Principally, lived experience work is about how experiences are understood and applied to benefit others. The AOD LEW uses lived expertise to connect, provide advice and support positive change. Many AOD LEW roles require competencies relevant to the role, however there are competencies that are shared aims across the workforce.

Foundational and continuous learning

AOD Lived Experience workers seek to identify areas where they can grow personally or professionally and take opportunities to learn and develop. To thrive in their role, they should:

- Understand the service systems, pathways in and out of services, availability of community supports and current system activity to provide system navigational support.
- Understand service user preferences and the benefits of harm reduction practices and abstinence-based approaches, knowing there are multiple pathways to self-determined healing.
- Recognise the value of and actively seek opportunities for personal growth and professional development.
- Keep up-to-date with the latest research and practice knowledge relevant to the workforce and apply this learning to their practice.
- Network with other members of the AOD LEW, maintaining a connection with the community to remain aligned to the discipline.

> You can't actually have cultural safety until Aboriginal people have self-determination. But you can do the best you can to ensure that a person is known, their culture is known, their mob is known—all those different intersections that attempt to create a safe, working place for them.
>
> – Aboriginal AOD lived experience worker, Victoria

> Authenticity is key in building relationships and rapport with people as a lived experience worker... your lived experience is what is of the highest value to people.
>
> – AOD peer worker, Victoria

Professional practice

AOD Lived Experience workers seek to understand relevant legislation, policies, standards and systems and work to align them with AOD LEW values. With a focus of accountability and integrity, they strive to:

- Work collaboratively with colleagues, respecting and supporting other disciplines and actively participate in co-learning opportunities.
- Work according to ethics, legislation, organisational policies and practice standards, understanding how they can be applied through lived experience values.
- Communicate effectively with different groups of people, building relationships with stakeholders, colleagues and service users.
- Balance passion with adaptability and diplomacy, understanding that culture change takes time and being heard and having influence is about effective communication, patience and flexibility.
- Understand the power of self-advocacy, individual advocacy and systemic advocacy and the role and scope of advocacy in their work.
- Protect and promote human rights for everyone, in all their work, using their personal experience to advocate for positive change.
- Understand organisational change principles, service development and quality improvement processes and how lived experience can enrich these.
- Recognise, embrace and practically support diversity and the necessity for culturally inclusive and culturally safe responses.

> Self-awareness is a foundation to all other values—it's important to have emotional intelligence for yourself and for others.
>
> – AOD lived experience worker, Victoria

Self-reflection and wellbeing

People in the AOD LEW understand that self-reflection, self-care and self-advocacy are important for their wellbeing and resilience. As a result, they aim to:

- Use wellbeing and resilience principles in their own lives and with others, utilising the practices that work best for them.
- Practically apply the principle of self-determination, supporting people to access the treatments, supports and services they choose.
- Know how to advocate for what they need to maintain their health and wellbeing.
- Use reflective practice to make the best use of their strengths, identify areas for improvement and growth and address challenges unique to AOD LEW roles.

Role specific skills and knowledge

The most prevalent role in Victoria's AOD LEW is that of peer worker. Peer support is founded on the emotional connection of people who have been there. Based on the foundation of authentic peer to peer relationships, AOD peer workers walk alongside people on their journey through services, aiding them to navigate and understand the supports available to them within the scope of the organisation and their role.

Peer support

The provision of peer support is grounded in the peer worker's ability to initiate and develop ongoing peer relationships. AOD peer workers are able to:

- Understand peer support is about connection and having positive interactions without the need for an outcome.
- Share experiences intentionally to normalise experiences, balance power, establish identification and build trust.
- Seek to understand and know the whole person, rather than reducing them to a single experience, situation, or label.
- Negotiate boundaries, recognising and attempting to minimise power imbalances through reflection and learning.
- Practice mutuality in their relationships, treating people as equals while acknowledging their different responsibilities.
- Create a safe space for people to share their experience through connection, practising empathy and vulnerability.
- Support and empower service users to work towards self-identified and determined goals.
- Understand and practice peer support with service users that have co-occurring needs.
- Practice curiosity and creativity to apply peer support skills and strengths in ways that are required for each unique relationship and the kinds of supports that work for them.

This list of knowledge and skills that are critical in practicing peer work are informed by the Victorian AOD Peer Workforce Core Competencies. These competencies were developed by SHARC in partnership with the Victorian AOD Peer Workforce Community of Practice, supported by the Strategy for the Alcohol and Other Drug Peer Workforce in Victoria (2019).

Many AOD LEW roles work strategically to effect positive change in service delivery and organisational culture. Advocacy at policy and service system levels delivered by AOD LE workers is often connected to the collective voice of service users. They understand that individual experience is connected to system change and have a drive to improve services and outcomes. This requires sound knowledge of participatory approaches and systemic advocacy levers.

Participatory approaches

Participation enables people to play an active and influential part in decisions that affect them and their communities. This requires AOD Lived Experience workers to:

- Use lived expertise to inform the development of services and assist in quality improvement initiatives.
- Work collaboratively with colleagues to enhance the provision of services and supports through lived experience perspectives.
- Understand participation as a human right – that people have a right to influence cultural, social, economic and political changes that affect them.
- Understand and challenge the impact of stigma, discrimination, prejudice and human rights breaches.
- Actively network and consult with people who access the service and their families in service, program, or activity design.
- Understand participatory approaches, the different levels of participation and how each level aligns with the principle of self-determination.

Systemic advocacy

AOD Lived Experience advisors and advocates draw on collective service user knowledge and research to inform systemic change and bring about changes to laws, policy, procedures and bureaucracy which cause or perpetuate injustice or inequity. People who work at this level:

- Understand collective issues at a systemic and/or community level and engage in work to affect positive change.
- Work to influence decision makers and use effective levers to achieve change.
- Provide strategic input from the lived experience perspective in service, program, or policy design.
- Elevate the voices of the AOD LEW and service users and advocate for service user partnerships and lived experience leadership.

> **The work is intentional—you show up, you're punctual, you create a safe space for people we're working with, you follow through with everything you say you're going to do, being your authentic self, being present.**
>
> – AOD peer worker, Victoria

WHY AOD LEW?

For organisations, having the benefit of an AOD LEW is not business as usual. A focus on the systems, processes and cultures that enable effective and meaningful lived experience practice is necessary before introducing the workforce to the service. Capability training, resources and supports are required, and evidence shows that success relies on organisation-wide understanding, commitment and willingness to transform.[43, 44]

SHARED UNDERSTANDINGS

It is not enough to employ people on the basis of their lived experience; shared understandings of how and why peer identity brings about change needs to underpin the role in all organisations.[45]

It is well established that engaging with people who are, or have been most directly affected by services, policies and programs is essential to understanding whether these different components of the system are achieving their aims. This is because AOD lived experience workers hold vital knowledge about what is needed from the system, both for individual care and at broader levels. This experiential expertise can support more effective and efficient services, delivering benefits for clinicians, policy makers and funders, as well as for service users and families.

Research into the impact of peer support is vast, and showcases a number of positive outcomes,[46] particularly if the workforce is adequately supported. Evidence speaks to the multiple benefits of lived experience work for those providing the service, those receiving it and for the organisations themselves.

The AOD LEW provides a range of positive outcomes for services and service users including:

- Information and insights that can lead to smarter decisions, better policies, more efficient funding allocations, and more effective services.[47]
- Increased engagement, facilitating a better understanding between people providing services and people using services.
- Influence on organisational policies and procedures that undermine effective service delivery.[48]
- The capability to influence the knowledge and attitudes of other workers, building meaningful relationships between staff and service users.[49]
- Offer a 'social movement for change' by providing visible exemplars, supporting and inspiring personal hope and cultural change.[50]
- An improved sense of hope, empowerment and social inclusion for those accessing services.[51, 52]
- Deliver on the important role of people with a lived experience in challenging stigma and discrimination.[53]

Overall, these findings indicate that if AOD Lived Experience workers are well trained and supported, they have the potential to bring a range of benefits to service users, services and systems.

The incorporation of AOD lived experience in services and across systems is built on the idea of 'nothing about us without us' – that there is an imperative for the participation and involvement of AOD lived experience in service design, delivery and policy making.

First invoked by the South African disability rights movement in the 1990s, 'nothing about us without us' became the clarion call of activists organising to overcome systemic oppression and empower people with lived and living experience. Today it is recognised that AOD lived experience is an indispensable ingredient for continuous improvement, essential to honouring human rights and representing genuine partnerships to deliver the best outcomes at individual, service, organisation and system levels.[54]

REFERENCES AND NOTES

1. Dudgeon, P., Darwin, L., Hirvonen, T., Boe, M., Johnson, R., Cox, R., Gregory, L., McKenna, R., McKenna, V., Smith, D., Turner, J., Von Helle, S., Garrett, L., 2018. We are not the problem, we are part of the solution: Indigenous Lived Experience Project report, University of Western Australia and Black Dog Institute, https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/lived-experience-report-finalnov-2018.pdf.
2. Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. National Lived Experience Development Guidelines: Lived Experience Roles. 2021, National Mental Health Commission.
3. Victorian AOD Program Guidelines, https://www.health.vic.gov.au/aod-service-standards-guidelines/alcohol-and-other-drug-program-guidelines.
4. The focus of consultant work is service improvement, with particular attention to practices, policies and procedures that effect access and equity. This work is sometimes referred to as service advocacy and involves leadership, co-design, community engagement, networking, planning, evaluation, facilitation and communication skills.
5. State of Victoria. Department of Health. Integrated treatment, care and support for people with co-occurring mental illness and substance use or addiction: Guidance for Victorian mental health and wellbeing and alcohol and other drug services. July 2022.
6. Key to the qualification for designated roles is that the experiences were so significant they caused the individual to reassess and often change their lives, their future plans and their view of themselves.
7. Department of Health and Human Services (2018). Working together with families and carers: Chief Psychiatrist's guideline. Melbourne: Victorian Government.
8. Care relationships include a range of pre-existing relationships and people in them may not identify as a 'carer'. A care relationship is not only about what one person does for another person and can be reciprocal.
9. Mental Health and Wellbeing Bill 2022 (Vic), sec. 4.
10. Best, D., Laudet, A. The potential of recovery capital. Peterborough: Citizen Power Peterborough; 2010. p. 6.
11. Best, D., Laudet, A. The potential of recovery capital. Peterborough: Citizen Power Peterborough; 2010. p. 6.
12. Cloud, W. and Granfield, W. (2009). Conceptualising recovery capital: Expansion of a theoretical construct, Substance Use and Misuse, 42, 12/13, 1971-1986.
13. Sherry Mead, 2014. Peer-Support – A Theoretical Perspective.
14. Psychologists studying human behaviour have observed that relationships and therefore network ties, tend to develop spontaneously between people with common backgrounds, values and interests.
15. Cohen, S. (2004). Social Relationships and Health. American Psychologist, 59(8), 676–684. https://doi.org/10.1037/0003-066X.59.8.676.
16. The Power of Words: Having alcohol and other drug conversations: A practical guide, 2021, p.4.
17. The Power of Words: Having alcohol and other drug conversations, 2021.

18. Royal Commission into Victoria's Mental Health System Final Report, 2021, Volume 1, Glossary, pp.652-677.
19. Other professions, such as the AOD living experience workforce and the consumer workforce in mental health, while they align in many ways, have their own frameworks that are specific to their professional practice.
20. State of Victoria, Royal Commission into Victoria's Mental Health System, Interim Report, Parl Paper No. 87 (2018–19).
21. Our Future Project Partnership (2021). Our Future: Developing Introductory Training for the Lived and Living Experience Workforces in Victoria. Self Help Addiction Resource Centre (SHARC): Melbourne.
22. Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. National Lived Experience Development Guidelines: Lived Experience Roles. 2021, National Mental Health Commission.
23. White, W. (2004). The history and future of peer-based addiction recovery support services. Prepared for the SAMHSA Consumer and Family Direction Initiative 2004 Summit, March 22-23, Washington, DC.
24. Detar, D.T., Alcoholics Anonymous and other twelve-step programs in recovery. Prim Care. 2011 Mar;38(1):143-148.
25. Donovan, D.M., Ingalsbe, M.H., Benbow, J., Daley, D.C. 12-step interventions and mutual support programs for substance use disorders: an overview. Soc Work Public Health. 2013;28(3-4):313-32.
26. Alcoholics Anonymous, founded in 1935, was established as a 'kinship of common suffering'. Today it retains a non-professional and non-hierarchical structure. and multiple other fellowships have emerged internationally based on this model.
27. The modern recovery advocacy movement seeks to address political and legislative actions as much as it seeks to address social misunderstanding, stigma and discrimination.
28. VIVAIDS (now known as Harm Reduction Victoria or HRVic) was founded in 1987 in response to the HIV/AIDS crisis.
29. In 1996-97 HRVic established Victoria's first funded peer-led projects in sex work, Hepatitis C and RaveSafe, as well as the Young Injectors Peer Education and Advocacy Project.
30. White, W. (2007). The new recovery advocacy movement in America, Addiction 102(5):696-703.
31. We Help Ourselves (WHOs) in NSW was established in 1972.
32. These organisations amalgamated in 1995 to become the Self Help Addiction Resource Centre (SHARC).
33. White, W. L. (2009). Peer-based addiction recovery support: history, theory, practice and scientific evaluation, Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Intellectual Disability Services, Chicago.
34. Chapman, J., Roche, A.M., Kostadinov, V., Duraisingam, V., Hodge, S. (2020). Lived Experience: Characteristics of Workers in Alcohol and Other Drug Nongovernment Organizations. Contemporary Drug Problems, 47(1), 63-77.
35. The Association of Participating Service Users (APSU) is the peak Victorian consumer body for people who use, have used, or are eligible to use alcohol and other drug (AOD) services, including family members and significant others impacted by AOD issues.
36. Association of Participating Service Users, 2010. Straight from the source – A practical guide to family participation in the Victorian alcohol and other drug sector.

37. Self Help Addiction Resource Centre, Peer Support Capacity Building Project, 2014 -2016.

38. Manning, V., Savic, M., Thorn, P. (2016). An evaluation of SHARC's Peer Support Capacity Building Project, Turning Point, Eastern Health, Melbourne.

39. In 2017, Victoria's AOD Peer Workforce Community of Practice was established, supported by a comprehensive peer worker training program and organisational readiness training. Soon after came discipline specific supervision and the introduction of Intentional Peer Support to support the workforce.

40. Lived Experience Workforce Strategies Stewardship Group 2019, Strategy for the Alcohol and Other Drug Peer Workforce in Victoria. Self Help Addiction Resource Centre (SHARC), Melbourne.

41. While primarily employed within the AOD sector, AOD Consumer LE workers also work in the mental health and wellbeing systems, criminal justice system, acute and community health settings.

42. AOD consumer lived experience is also that of accessing or attempting to access services.

43. Reeves, V., Loughhead, M., Halpin, M.A. et al. Organisational Actions for Improving Recognition, Integration and Acceptance of Peer Support as Identified by a Current Peer Workforce. Community Ment Health J (2023)

44. Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., Saunders, M. National Lived Experience Workforce Guidelines. 2021, National Mental Health Commission.

45. Ahluwalia, A 2018. Peer Support in Practice – A Research Report with Recommendations for Practice. Inclusion Barnet 2018

46. Gillard S, Gibson SL, Holley J, Lucock M. Developing a change model for peer worker interventions in mental health services: a qualitative research study. Epidemiol Psychiatry Sci. 2015 Oct;24(5):435-45.

47. Gallagher, C. and Halpin, V. (2014). The Lived Experience Workforce in South Australian Public Mental Health Services. Central Adelaide Local Health Network Mental Health Directorate Adelaide, SA.

48. Western Australian Association for Mental Health (WAAMH). A Peer Work Strategic Framework for the Mental Health and Alcohol and Other Drug Sectors in Western Australia. West Perth, WA.

49. Pound, L., Judd, K. and Gough, J. (2011). Peer Support for Women Living with Mental Health Issues: The Views of ACT Women, Women's Centre for Health Matters, Canberra, 2011.

50. ibid

51. Davidson, L., et al., Peer support among persons with severe mental illnesses: A review of evidence and experience. World Psychiatry, 2012. 11(2): p. 123-128.

52. Social inclusion and connectedness were found to include improved interpersonal relationships and contribute to a sense of positive culture that fostered feelings of belonging and decreased social isolation. See: Ahmed, A.O., et al., The professional experiences of peer specialists in the Georgia mental health consumer network. Community Mental Health Journal, 2014. 51(4): p. 424-36.

53. Corrigan, P.W., Kosyluk, K.A. and Rüsch, N. Reducing self-stigma by coming out proud. American Journal of Public Health, 2013. 103(5): p. 794-800.

54. World Health Organization Regional Office for Europe. User empowerment in mental health: A statement by the WHO regional office for Europe. Copenhagen: World Health Organisation; 2010.