Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Present But Not Supported: Inadequate Supervision for Lived Experience Workers in Australian Mental Health

Liam Hodge
lhodge3@myune.edu.au

University of New England
Tania Pearce
University of New England
Sarah Wayland
Central Queensland University
Myfanwy Maple
University of New England

Research Article

Keywords: Peer Work, Lived Experience Workforce, Supervision, Discipline-Specific Supervision, Narrative Inquiry, Mental Health Workforce

Posted Date: June 11th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9877981/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License. Read Full License

Additional Declarations: No competing interests reported.

Abstract

Background

Peer Workers are increasingly employed in Australian mental health services. Unlike clinical staff, who receive discipline-specific supervision, Peer Workers routinely lack structured support. There is currently limited evidence to understand Australian Peer Workers' supervision experiences.

Purpose

This study sought to understand Peer Workers' supervision experiences in Australian mental health settings, examining supervision expectations and requirements, barriers, and consequences of inadequate support.

Methods

Using a qualitative narrative inquiry framework, 18 semi-structured interviews were conducted with Lived Experience workers across four Australian states. Reflexive thematic analysis examined experiences across temporality, sociality, and place dimensions.

Results

Ten themes were identified from data analysis - revealing that Lived Experience workers require effective supervision that is externally provided, discipline-specific, regularly scheduled, with trained Lived Experience supervisors in protected time. Participants described how current supervision was constrained by power imbalances with line managers, conflation with performance management, lack of discipline-specific expertise, and positioning as optional rather than essential. When organisations failed to provide supervision, Lived Experience workers self-organised alternatives through unpaid labour, inadvertently legitimising organisational withdrawal from responsibility. The interviews showed that traits of an effective supervisor were a deep grounding in Lived Experience values; a commitment to mutuality and non-hierarchy, a facilitative capacity to "sit in the mud" and through a non-judgemental presence to protect the distinct integrity of the role.

Conclusions

Peer Workers possess clear knowledge of supervision requirements and access barriers; the challenge to the delivery of supervision is impacted by political will and resource allocation. The current status of supervision offerings to peer workers perpetuate marginalisation, enabling clinical drift, and impacting lived experience work's distinct epistemology. Discipline-specific supervision is essential to workforce wellbeing, practice integrity, and Lived Experience work’s transformative potential. The absence of adequately resourced supervision for Lived Experience workers constitutes systemic inequity.

Introduction

Supervision for Lived Experience workers within the Australian mental health system remains inconsistent, frequently limited in scope or entirely unavailable (Castles et al., 2023). This lack of access to equitable support mechanisms, relative to clinical colleagues, places Lived Experience workers at a heightened risk of experiencing burnout, vicarious trauma, and the emotional demands of navigating persistent boundary tensions across service user and interprofessional team relationships (Hodge et al., 2026; Chreim et al., 2026; Ser et al., 2024). When support is offered, clinician-led frameworks are relied on that are not discipline-specific. This overlooks unique nuances and values of Lived Experience practice and, paradoxically, increase workers’ experience of stigmatisation within the services they are employed to transform (Castles et al., 2023; Norton, 2025; Reeves et al., 2024; Shaw et al., 2026). Supervision by non-Lived Experience professionals risks the co-option of the workforce into clinical paradigms, potentially distancing Lived Experience workers from their foundational values (Hodge et al., 2026; Norton, 2025).

Research from UK, USA and Australia identified the need for discipline-specific supervision to maintain the integrity of Lived Experience work, supporting role clarity, and enabling reflective professional development (Byrne, Roennfeldt, et al., 2021; Byrne, Wang, et al., 2021; Repper et al., 2013). Within Australian contexts there is significant variability in how supervision is conceptualised and practiced within the Peer Workforce (Castles et al. 2023). A recent scoping review (Hodge et al., 2026) showed that there are currently no models of supervision within the literature developed by Lived Experience workers to work alongside Lived Experience workers in the mental health system. These reviews demonstrate that whilst discipline-specific supervision was widely recognised as necessary for upholding the fidelity of Lived Experience practice, it was often unavailable despite best-practice recommendations. Lived Experience leadership consistently advocates for supervision provided by senior or experienced Lived Experience workers, yet government and clinician-led frameworks often fail to mandate these requirements (Castles et al., 2023). This discrepancy contributes to persistent challenges, including significant role ambiguity, non-formalised roles where workers develop their own role definitions without organisational guidance (Robinson & Isaacs, 2025), and the conflation of professional supervision with administrative line management. When supervision is reduced to a managerial or administrative task, Lived Experience workers frequently report feeling unsupported and devalued in their roles (Castles et al., 2023; Hodge et al., 2026). Given the inherent isolation of Lived Experience workers within clinical teams and the rapid growth of the workforce, there is an urgent need for supervision practices that reflect the practical reality of the field (Hodge et al., 2026; Watson et al., 2024). This study centres Lived Experience workers' voices to examine their experiences of supervision, the conditions that enable or undermine effective support, and the structural factors shaping supervision provision in Australian mental health services.

Methodology

Study Design

This qualitative study is underpinned by an interpretivist paradigm, asserting that knowledge regarding Lived Experience supervision is socially constructed through the experience and narratives of the Lived Experience workforce themselves. The research design is guided by Clandinin and Connelly (2000) Narrative Inquiry framework, three-dimensional narrative inquiry space of Temporality, Sociality, and Place to explore participants' experiences and the storied nature of their professional roles. This structured application of narrative dimensions for data analysis is consistent with contemporary approaches to narrative inquiry that seek to systematically derive meaning while preserving and valuing individual stories (Halverson, 2026).

Ethical Considerations and Reporting Guidelines

Ethical approval

for this research project (HE-2025-2212-4448) was granted by the University of New England Human Research Ethics Committee (01/02/25 – 01/10/26). All participants provided informed consent prior to participation, understanding their right to withdraw at any time without consequence, and were assured of confidentiality and anonymity through pseudonymisation. To ensure comprehensive and transparent presentation of findings, the study's methodology and reporting is aligned with the Standards for Reporting Qualitative Research (SRQR) guidelines (O'Brien et al., 2014).

Participant Recruitment

Using a purposeful sampling strategy, Author 1 recruited using a multi-pronged approach, which involved a targeted social media campaign on platforms relevant to the mental health and lived experience work sectors, alongside direct email correspondence with organisations known to employ Lived Experience workers within mental health services with the following inclusion criteria.

- Currently working in an identified Lived Experience role.
- Receiving dedicated supervision.
- Over the age of 18 and able to provide informed consent.
- In paid or volunteer Lived Experience roles.

Those who expressed interested were provided with a Participant Information Sheet, with potential participants completing an informed consent document. Participants were also offered a Visa/Mastercard voucher ($40 AUD) to compensate for time. This amount was selected inline with National Health and Medical Research Council (NHMRC) guidelines for renumeration for participants, and guided by the Social, Community, Home Care and Disability Services Industry Award (SCHADS) (Fair Work Ombudsman, 2025; NHMRC et al., 2019).

Data Collection

Data collection involved gathering information on participants' professional backgrounds, including their years of experience in Peer Work and their level of sector-specific education. Basic demographic details, such as age, gender, ethnicity, and socioeconomic factors, were also recorded. Primary data was collected through individual, semi-structured interviews conducted by Author 1, with each participant engaging in a single session lasting between 60 and 90 minutes. These interviews were guided by open-ended questions designed to explore participants’ experiences of Peer Work supervision, the impact on their practice, and their perspectives on necessary improvements. All interviews were audio-recorded to ensure an accurate record of the narrative.

Data Analysis

The analytical process was guided by Clandinin and Connelly's (2000) three-dimensional narrative inquiry space, which provided an initial deductive framework for understanding the storied plotlines of participants' experiences. Following transcription and de-identification of all participant data, an iterative process of familiarisation with the data was undertaken. NVivo 14, was used to initially code into the three broad dimensions of Narrative Inquiry:

1. **Temporality (Past, Present and Future)**: Exploring the ongoing cost of Lived Experience over time.

2. **Sociality (Relationships, Power, Protection)**: Examining what makes supervision work or fail through relational dynamics.

3. **Place (Structure, Integration, Positioning)**: Investigating where Lived Experience workers are (and are not) supported within organisational structures.

Inductive thematic analysis was conducted, allowing for identification of specific themes and sub-themes directly from the participant narratives. This iterative process of moving between deductive application of the Clandinin and Connelly's framework and inductive generation of sub-themes resulted in a total of ten distinct themes, organised as follows in Table 1. To ensure the trustworthiness and consistency of the findings, consultations were held across the research team to consolidate the thematic process. This collaborative approach addressed potential biases and strengthened the interpretive thoroughness of the analysis.

Results

Twenty (n = 20) interviews were conducted. 18 participants met eligibility criteria and were included in analysis; two transcripts were identified as duplicates and were removed during the data cleaning process. While all 18 participants contributed to the qualitative findings via interview, 12 chose to complete the optional pre-interview questionnaire, which provided the specific demographic and professional data for this cohort (thus demographic information for six participants is missing). These participants predominantly identified as male (n = 8), with three identifying as female and one as non-binary. Geographically, representation was concentrated across New South Wales (n = 4), Victoria (n = 4), and South Australia (n = 3), with one participant located in Western Australia. No participants identified as Aboriginal and/or Torres Strait Islander.

In terms of academic attainment, 11 of the 12 participants held university qualifications (eight bachelor's degrees and three master's degrees). Professional tenure within the sector was also significant, with nearly half the participants reporting more than six years of practice. Participants most frequently reported receiving supervision monthly (n = 5) or quarterly (n = 5).

Theme one: Past, Present and Future: The Ongoing Cost of Lived Experience

Lived Experience as Ongoing Professional Credential: The Daily Cost of Embodied Knowledge

Participants described lived experience as a professional credential requiring daily emotional and psychological labour:

"So I can see the challenges that people are facing with their own mental health that are parallel to my own...There's something that I can bring to this situation." (Participant 5)

And;

"I think it's a superpower… my lived experience is my superpower" (Participant 12)

This expertise was continuously embodied in their practice, drawing on personal experiences of distress, system contact, and recovery to inform their work with consumers:

"I've got a Lived Experience and I'm bringing that with me every day. You went to university for three years and you paid this money. I'm paying every single day and every moment of my life to bring myself to this role. When I'm talking to that clinician, they don't understand that. They think I just went and did a course." (Participant 18)

Supervision Experiences: Performance Management, Not Professional Development

Participants reported that internal or organisation provided supervision was characterised by performance-oriented feedback, rigid formats, operational timing that created competing demands, and a lack of confidentiality that led to self-censorship. When supervisors also held line management responsibilities, participants described withholding information due to concerns about career progression and how their disclosures would be perceived:

"I don't feel value in the conversation. I don't feel like it gets to a place where I'm able to think, 'OK, this is how I could have dealt with this or sorted that out.' It's more, 'Yep, you did a great job' or 'you need to do your notes better'...Sometimes we have set questions that we're going to talk about and then I get stuck in those questions and maybe don't talk about what's on my mind. It is normally done on a shift...Whereas my other supervision was done outside of work or a dedicated time where I had nothing else to do." (Participant 11)

And;

"Obviously I know that [I am] human as well. So, whatever I say, they're going to be thinking about, they're going to remember. So, if I'm saying I'm struggling with something and then the next week I want to go for a higher position and now the person that's employing for that, I know that they're going to [remember]." (Participant 11)

In contrast, participants who accessed externally funded, Lived Experience-led supervision described fundamentally different experiences marked by honesty, choice, and alignment with Lived Experience work values:

"Having an outsider where I could be completely honest with how I was feeling about things, different interpersonal issues. And knew that there was nothing that was going to come back to the organisation or impact my work...I think having space to talk about how to stay in the peer work, like stay in the peer space and not go clinical" (Participant 11)

Despite National Lived Experience (Peer) Workforce Development Guidelines advocating for discipline-specific supervision, participants reported a significant gap between policy and practice, with many having to advocate repeatedly for access to external supervisors or receiving no dedicated supervision at all (Byrne, Wang, et al., 2021).

Lived Experience work as Calling: Fighting Against What Pushes People Down

Participants explained that lived experience work was experienced less as employment and more as "calling", driven by personal history, moral purpose, and commitment to transformation emerging from profound experiences of loss, injustice, and system failure. Here, the "calling" was framed as temporal transformation: past trauma (then) and system contact converted into present purpose (now) and future (next) commitment. "The Then" is characterised by

experiences of loss, harm, and system failure. “The Now” represents finding a role where Lived Experiences becomes credential and moral authority. “The Next” is sustained through commitment to preventing others from experiencing what they endured similar harms:

“I had a friend of mine really suffering suicidal thoughts…Just seeing within your life based on a particular experience, I felt really broken down when she took her life. So, I felt that I could make more impact being a Peer Worker than just, you know, choosing the normal career or normal venture and just going to work every day... I see that as something that I could channel as an energy, that's a boost to help me keep going; to help me try to do my work better...It's like my drive, like my passion.” (Participant 4)

Roles became a calling, sustained through ongoing commitment. Other participants described similar experiences prompted by system inadequacy:

“Looking into the healthcare system as a worker really changed my point of view about it. The healthcare system in general has so many drawbacks in it that are resulting in negative outcomes for people, not only the consumers but also the workers…Three reasons why we're there: one is to use our lived experience as an asset; two is to improve the outcomes for our consumers; and three is to improve the system. And when we improve the system, everything else benefits.” (Participant 5)

Theme two: Relationships, Power, Protection: What Makes Supervision Work or Fail

Co-Reflection Without Discipline-Specific Supervision Erodes Lived Experience Work Values

Participants consistently distinguished between co-reflection, group supervision, and discipline-specific supervision, describing each as serving a different function in their professional support. When organisations substituted co-worker interactions or informal lived experience contact for structured supervision, participants reported that sessions often devolved into shared venting rather than opportunities for growth, exploration, or skill development:

“Sometimes it can feel a bit like just having a whinge together rather than having someone kind of help me explore these things and maybe look at alternative ideas, resources, solutions. It can just feel like this is ****. Yeah, this is ****.” (Participant 9)

External discipline-specific supervision was described as creating conditions for honesty and serving as protection against clinical drift, enabling participants to maintain alignment with Lived Experience values in environments where clinical perspectives risked eroding their relational approach:

“Having a space to talk about how to stay in Peer [Lived Experience] Work…sometimes the [clinician] might be saying really negative things and the more you hear those things, almost stigmatising things, I guess you're going to start to sway to those views…focusing on staying here is probably an important part that I like to reflect on in Supervision” (Participant 11)

Group supervision offered complementary support through collective reflection, providing validation, diverse perspectives, and a shared space to address workplace culture:

"It is helpful if you can have maybe even better than one person is better to be able to kind of discuss these things in a in a group setting because then you get a range of perspectives and it yes it kind of opened my mind to other possibilities that discussion." (Participant 8)

Participants consistently articulated a need for both individual and group formats, viewing them as complementary rather than interchangeable; substituting one for the other resulted in gaps in support that neither format alone could address.

Discipline-Specific Expertise: Limits Lived Experience Work Drifting toward Clinical Conformity

Participants described discipline-specific expertise as essential for effective Lived Experience work supervision, requiring supervisors to be grounded in Lived Experience values, actively connected to the consumer movement, and able to recognise when practice drifted from discipline principles:

"When we're looking at discipline specific supervision for other disciplines, you've got your clinical supervision for clinicians. When you're thinking of supervision for psychologists and therapists... the supervisors will have the same training, background, and expertise to provide supervision. We wouldn't expect to see a clinical psychologist receive supervision from a nurse or occupational therapist. It's the exact same logic with Peer [Lived Experience] Work where... the clinical expertise can't really be extended to the Lived Experience workforce" (Participant 13)

This expertise was not understood as a static credential but as an ongoing capacity that functioned in practice through values alignment, practical resource provision, and the ability to see workplace dilemmas through a Lived Experience lens. When supervisors possessed this expertise, participants described supervision that began with values alignment and returned to it consistently, creating a foundation for reflecting on practice, navigating scope, and maintaining connection to the broader movement:

“The first session I had with her, she said. Look, I don't normally do every session on this, but let's go through the Peer [Lived Experience] values. Let's see where you're aligning in your current role. Let's just go. And it was really, I found it really helpful because we just, we went through each one and worked out where there's certain things that I'm not aligning, why I'm aligning.” (Participant 18)

And;

“[The supervisor] is really good at sending me through, like a summary of our catch ups...there's sometimes those little bit of extra stuff that she'll help support me with after...I'm going to send her through my position description today...she's going to have a look at some of the stuff that I said I was questioning whether that's within my role or not” (Participant 18)

Some participants also identified that some experienced supervisors had shifted toward managerial norms, becoming disconnected from lived experience principles and replicating the hierarchical dynamics that discipline-specific supervision was intended to counter:

“Like to be super blunt, managerialist dirtbags who left their Peer [Lived Experience] values way back in the rearview mirror... [they have] become very disconnected from Peer practise and [their] peer principles and are no longer applying those Peer principles. In [their] role… [they have] become indoctrinated into the cult of bureaucrat.” (Participant 17)

Crucially, participants expected this expertise to be modelled within the supervisory relationship itself; a supervisor's commitment to mutuality and non-hierarchy was described as what distinguished Lived Experience supervision from traditional clinical oversight.

Supervision Fails When Hierarchical Structures Override Relational Trust

Participants identified three conditions of supervision as foundational: trust that enabled honesty, flexibility that centred supervisee agency, and a non-hierarchical relationship that embodied Lived Experience work’s relational values:

“So I think you really have to develop relationships based on respect and mutual trust where people are willing to share some of their experiences with you and so you need to have a like it's very important to have a diverse network so that you have that lived experience knowledge.” (Participant 14)

Effective supervision required flexibility to adapt format, frequency, and focus to support the practice:

“I like the flexibility [of supervision] because I often need something different each time...Sometimes I'm kind of like, yep, cool, I'm feeling good. I just need someone to reflect back to me that I'm doing alright” (Participant 9)

Non-hierarchical supervision did not mean absence of expertise or challenges. The supervisor's role was facilitating the supervisee's thinking rather than prescribing correct answers:

“He [supervisor] wouldn't tell me what to do necessarily, he would probe me with questions in scenarios and get me to think about things a little bit differently through questions...giving examples of his own when he's been in a similar situation and what worked and what didn't work, but not in a way that's telling me to do those things.” (Participant 11)

When these conditions were absent, particularly where supervisors also held line management responsibilities, supervision was experienced as performance management or tokenistic check-ins that prioritised organisational compliance over professional development and emotional support. Participants described rigid structures, prescribed questions, and administrative focus replacing the relational trust and flexibility they identified as essential for meaningful reflection and growth.

‘Sitting in the Mud’: The Relational Foundation of Lived Experience Work

Participants described the relational foundation of lived experience as the practice of holding space without judgement or urgency to fix, a practice they referred to as "sitting in the mud":

“Not trying to change someone too much and just being there as a listener sitting in the mud with someone, especially within that crisis work, which is what I do. So, people are coming in and maybe only seeing you once and you're just giving them an hour of just sitting and non-judgmental listening, which is really nice.” (Participant 11)

This approach, characterised by non-directive presence, non-judgmental listening, and a willingness to sit alongside someone in distress without prescribing solutions, was identified as what distinguished Lived Experience work from clinical intervention. Participants reported that effective supervision mirrored this same relational approach; supervisors grounded in Lived Experience values modelled patience, validated non-directive practice, and supported supervisees to navigate ethical dilemmas and organisational pressures without imposing answers:

“When I sit there, talk with her, and often things like the ethical dilemma that I bring to it, I know, I know, like where I'm coming from is correct. But having someone that's so like deeply embedded in the peer like principles and stuff, be able to come off and back that that gives me that little bit of empowerment of like cool, like I'm on the right track. I've got these other people behind me.” (Participant 18)

When workplace structures require Lived Experience workers to operate outside their scope or adopt clinical frameworks, discipline-specific supervisors provided values-based analysis and validation that enabled participants to maintain boundaries and feel supported in their distinct approach. Supervision that understood "sitting in the mud" functioned as both a mirror of Lived Experience practice and a protective mechanism for it.

Theme Three: Structure, Integration, Positioning: Where Lived Experience Workers Are (and Are Not) Supported

Present But Not Integrated: Lived Experience Workers' Subordinate Positioning

Participants described being physically present within organisations without corresponding integration into decision-making, team processes, or clinical discussions. This positioning was experienced as tokenistic, where organisations publicly valued Lived Experience but consistently shut down Peer Worker contributions when they challenged clinical perspectives or offered alternative approaches:

"It often feels that Peer Work is very tokenistic of just "we really value Lived Experience voices, here's a Peer Worker,'... it's like you try and join in the conversations with the people who are in a conversation, and they look at you being like 'why are you here?" (Participant 13)

And;

"So let's just say my manager is a great person and she has taken a time to listen to me and account for what I've said. But at the start. She said there was no role for me in the team beyond being on the payroll. I had no capacity to make any contribution." (Participant 5)

This subordinate positioning contributed to isolation, burnout, and emotional distress, with participants describing the experience of witnessing harm they were unable to influence. Organisations that had invested in expanding the Lived Experience workforce were described as approaching integration superficially, recruiting the workforce without undertaking the cultural change necessary to genuinely include them:

“People just think, oh, we should get Peer [Lived Experience] workers, and they don't think it all the way through. So they haven't done the culture change. They haven't done all of that kind of deep thinking. It's really just like Peer [Lived Experience] workers are the dressing on the salad. You know, that's the thing that we add and then, you know, bingo bango.” (Participant 17)

The weight of these hierarchical structures reinforced participants' need for supervision that remained flexible, relational, and external to the organisational dynamics that contributed to their marginalisation.

Professionalisation Risks Reproducing the Exclusion Lived Experience Work Challenges

Participants held diverse and often conflicting views about professionalisation, describing it as both a pathway to structural legitimacy and a risk of reproducing the exclusionary gatekeeping that Lived Experience work was founded to challenge. Some participants described professionalisation as necessary for recognition, noting that the transition from voluntary, unpaid contributions to a recognised discipline with its own values and principles represented significant progress:

“In the beginning, a lot of the work was voluntary and then they expected you to be grateful for giving your time for free...now I think that the workforce has become more professional and a discipline in its own right with its own values and principles. Yes, it's not just a tick box exercise, now it's part of the national standards and a requirement.” (Participant 14)

Others viewed it as essential for providing the labels and structures needed to be taken seriously within multidisciplinary teams and the broader medical system:

"We're constantly fighting against the medical system to be recognised saying, hey, no, recognise us as a discipline, recognise us as a collective. And a lot of the time it ends up coming down to the labels. At much as sometimes having those labels can suck, not align with our values and how we authentically hold ourselves within lived experience roles, we can still hold onto the hope that it could potentially be something we can utilise to take a step in a direction of where we want to be going" (Participant 13)

However, participants also expressed significant concerns that professionalisation would facilitate clinical co-option, attract practitioners disconnected from the consumer survivor movement, and create educational barriers that excluded people whose lived experiences of extreme states, involuntary treatment, and system contact were precisely what made them effective Peer Workers:

“I personally am extremely anti the creation of a professional body. I think it's a product of being a small discipline that emerged in the last 40 years...it's still very much in a lot of places seen as supported employment...I have a real concern about the way in which Peer [Lived Experience] Work is shifting to have a Peer workforce that is entirely essentially people like me, privileged, tertiary educated white people who've had relatively easy experiences of the mental health system and it's not leaving space for people who experience voices, who experience extreme states, who are on medications, who've been on CTOs, who've experienced involuntary treatment. And I think this professionalisation is just a way of pushing...moving further towards that para-clinician role.” (Participant 17)

Participants described professionalisation as acceptable only if it protected core Lived Experience discipline values, avoided educational gatekeeping, and centred cultural safety; without these safeguards, they feared it would erase the transformative foundations of the role it claimed to legitimise.

Discussion

There is a dearth of literature on Lived Experience workers encounters of supervision in mental health settings. The findings of this qualitative study reveal a critical disconnect where Lived Experience workers possess clear knowledge of what constitutes effective supervision (external, funded, discipline-specific, culturally safe, with trained supervisors and protected time) in opposition to organisations who lack the external mandates compelling investment in these structures. The absence of streamlined accreditation requirements for Lived Experience supervision and frameworks for practice removes organisational accountability and positions supervision as discretionary rather than essential infrastructure.

What Peer Workers Know About Supervision

Participants in this study articulated clear requirements for effective supervision, which aligns with existing evidence for other professions. They identified that supervision should be external to management structures, organisationally funded, discipline-specific, culturally safe, delivered by trained supervisors, occur during protected time, and allow supervisor choice. The Victorian Consumer Perspective Supervision Framework emphasises principles and values that guide reflexive practice, promote system change, and improve consumer rights and outcomes, distinguishing its focus from clinical supervision (Victorian Department of Health, 2023). The consequences of inadequate supervision, including isolation, burnout, inability to process challenging experiences, and erosion of confidence in Lived Experience practice, were consistently described across the interviews. Equally, participants who accessed quality supervision described validation of their expertise, confidence to advocate within clinical teams, space for honest reflection without fear of workplace consequences, and sustainability in emotionally demanding roles. Participants are not seeking emotional support; they articulated a need for supervisors who could model a non-judgmental stance and provide strengths-focused, objective performance evaluation that respects peer values rather than clinical performance indicators (Edwards et al., 2026).

This alignment between Lived Experience workers' experiential knowledge and evidence-based requirements of supervision is not unique to Australia. For example, Lara et al. (2026), surveying 101 Peer Workers across 14 countries, found that while participants possessed clear understanding of effective supervision requirements and preferred lived experience-led models, most received clinical supervision instead, mirroring the disconnect documented in this study. The problem is that organisations lack external mandates compelling investment. Clinical disciplines maintain supervision through professional registration requirements, workplace health and safety obligations, and accreditation standards. Lived Experience work lacks equivalent structural protections, positioning supervision as optional professional development rather than essential workforce infrastructure, despite the unique demands of drawing on lived experience daily.

Structural Marginalisation Creates Supervision Inadequacy

The inadequacy of supervision for Lived Experience workers is not an isolated workforce development failure. It is a symptom of broader structural marginalisation within mental health systems. Participants described being physically present in organisations without corresponding integration into decision-making, team processes, or valued roles, lacking the authority, resource control, and cultural legitimacy necessary to practice Lived Experience work authentically or influence organisational cultures.

This pattern is not unique to Australia. The National Lived Experience (Peer) Workforce Development Guidelines identified that a mature supervision system should provide flexible and resources supervision options to the Lived Experience workforce (Byrne, Wang, et al., 2021). Yet, Edwards et al. (2026) found that even in the United States, where Lived Experience is recognised as an evidence-based discipline, many supervisors remain clinically orientated and unfamiliar with core Lived Experience principles, contributing to role confusion and burnout. Internationally, Lived Experience workers are positioned as optional additions rather than integral practitioners, and their supervision follows accordingly: treated as a discretionary add-on rather than essential infrastructure (Jorgenson & Schmook, 2014; Kilpatrick et al., 2017). In Australia, Reeves et al. (2024) found that 16 of 18 Lived Experience workers reported experiencing stigma from colleagues, with participants describing being psychologically harmed in workplaces where leadership failed to actively champion Lived Experience roles. Kilpatrick et al. (2017) found that staff viewed Lived Experience workers as a "cheap option to do something that always looks good," creating a structural ceiling where roles are conceptualised as ongoing entry-level positions without clear career pathways. This positioning ignores the emotional and relational labour inherent in lived experience, labour that requires structured debriefing as a professional necessity rather than an optional extra (Cao et al., 2026).

When these structural forces converge, they produce a tokenistic cycle: if a Lived Experience worker is not a cohesive part of the team but is instead treated as an add-on, the supervision they receive will inevitably reflect that positioning (Kilpatrick et al., 2017). Lived Experience workers' experience of stigmatisation, reinforcing the cycle of marginalisation that supervision should interrupt (Shaw, et. al. 2026). Organisations that have not defined a clear structural place for Lived Experience workers to practice, contribute, and grow will not invest in the supervision infrastructure required to sustain them. Organisations need to have a ‘whole-of-organisation’ strategy and commitment for effective integration (Byrne et al., 2021). The result is a self-reinforcing pattern where marginalisation produces inadequate supervision, and inadequate supervision deepens marginalisation, highlighted by participants in this study.

The absence of adequate supervision infrastructure does not mean Lived Experience workers simply go without. Participants described self-organising alternatives: seeking unpaid co-reflection spaces outside work hours, drawing on personal networks for informal debriefing, and advocating repeatedly for access to external supervisors that clinical colleagues received as standard. These initiatives demonstrate that Lived Experience workers recognise supervision as essential for safe practice. However, their existence is both necessary and problematic: necessary because organisations are failing to provide adequate support; problematic because self-organised alternatives reduce the impetus for organisations to invest in proper provision (Jorgenson & Schmook, 2014). Lived Experience Workers who lack financial resources, supportive colleagues, or who work in isolated services cannot access these informal structures, meaning the burden of compensating for systemic failure falls disproportionately on those already managing substantial workloads and emotional demands. Framing these self-organised responses as evidence of workforce ‘resilience’ risks romanticising exploitation, transforming resourcefulness under constraint into a narrative that suggests such conditions are acceptable rather than demanding they change (Kilpatrick et al., 2017). While, these alternatives should not have been necessary, their existence underscores both the strength of the workforce and the depth of organisational failure.

Protecting Lived Experience Work Epistemology Through Adequate Supervision

Lived Experience work is grounded in a distinct epistemology that differentiates it from clinical practice. Norton (2025) identifies 'informality' as central to Lived Experience work; it is the mutual, equal, and authentic human connection that enables the change process. This ‘informality’ is not a lack of structure or professionalism but a deliberate departure from clinical relationships characterised by expert/patient hierarchies and intervention-focused interactions

(Byrne, Wang, et al., 2021; Norton, 2025). Peer Work relationships are built on shared experience, reciprocity, and what participants in this study described as ‘sitting in the mud’. This practice requires Peer Workers to draw on their own knowledge of distress while maintaining boundaries that protect both themselves and the people they support, a tension that discipline-specific supervision is uniquely positioned to hold. This ongoing complexity reinforces that discipline-specific supervision is not a one-off orientation but a continuous professional necessity (Chreim et al. 2026).

The emotional labour of ‘sitting in the mud’ requires what Edwards et al. (2026) refer to as the ‘support’ function of supervision. By building trust through mutuality, respect, and transparency, supervisors ensure that the Lived Experience worker's use of self remains a professional asset rather than a deficit. Without adequate supervision, Lived Experience work risks losing its distinct identity. Participants described organisational pressure to adopt clinical language and methods, shifting their role toward para-clinician rather than Lived Experience practitioner (Edwards et al. 2026). Foglesong et al. (2022) documented this dynamic, finding that non-Lived Experience supervisors often monitored for ‘signs of decompensation’ rather than supporting practice, pathologising the worker and eroding the trust essential for authentic Lived Experience work.

The tension observed in this study reflects a broader national concern that professionalisation must protect the sense of shared power and two-way support established in Lived Experience work (Byrne, Wang, et al., 2021). Participants who supported professionalisation saw it as creating structural legitimacy and protection from exploitation, while those who resisted it feared clinical co-option. Without addressing the underlying power dynamics that position Lived Experience work as subordinate to clinical practice, professionalisation risks producing credentials that do not translate to structural power, funding that remains discretionary, and supervision frameworks that exist on paper but are inadequately resourced. The difficulty of maintaining this 'fine line' highlights the absence of authentic allyship and Lived Experience leadership at the executive level. The National Lived Experience (Peer) Workforce Development Guidelines argue that protecting role integrity requires Lived Experience perspectives to be embedded 'at all levels of the sector,' including funding bodies and boards (Byrne, Wang, et al., 2021). Without this systemic guardianship, the individual 'mud-sitting' practitioner is left to resist clinical co-option in isolation. Discipline-specific supervision provides the protective space where Lived Experience work epistemology can be maintained. Without supervision frameworks developed alongside Lived Experience workers, the consequences are not merely individual but disciplinary: burnout, vicarious trauma, and the erosion of lived experience capacity to offer an alternative to clinical models through the informal, reciprocal relationships that enable recovery through connection rather than intervention. Effective supervision must evolve from, what is currently a mechanism of clinical surveillance into a site of disciplinary guardianship, ensuring that the transformative capacity to 'sit in the mud' is not merely permitted but protected as vital professional expertise.

Implications for Practice

Organisations employing Lived Experience workers must recognise that discipline-specific supervision is not optional enhancement but fundamental infrastructure. This requires committed investment: funding external supervision from trained Lived Experience supervisors, protecting time within work hours, ensuring supervisor choice, and resisting pressures to substitute line management or co-reflection for discipline-specific support. At a systems level, policy makers should mandate supervision standards through accreditation frameworks or funding body requirements. Without external accountability mechanisms, supervision provision will remain dependent on individual organisational commitment. Further research should prioritise the co-creation of supervision frameworks developed alongside Lived Experience Workers, ensuring that guidelines reflect epistemology rather than adapting clinical models.

Implications for Research

Research across diverse populations, including Aboriginal and Torres Strait Islander Peer Workers, culturally and linguistically diverse communities, and rural and remote contexts, would illuminate how cultural safety intersects with supervision adequacy. Longitudinal studies examining relationships between supervision quality, workforce retention, and practice integrity would strengthen the evidence base for systemic change.

Conclusion

This study reveals that supervision inadequacy for Lived Experience workers is not an isolated workforce development failure but a symptom of broader structural marginalisation within mental health systems. Lived Experience workers are present but not integrated, employed but not empowered, visible but not validated. This positioning produces a self-reinforcing cycle: marginalisation leads to discretionary supervision, discretionary supervision deepens marginalisation and Lived Experience workers are left to compensate for systemic failure through unpaid labour and self-organised alternatives.

Yet participants in this study were not passive recipients of inadequate systems. They articulated precisely what effective supervision requires and identified the structural conditions preventing its provision, the challenger here is accountability. Until external mandates, co-created frameworks, and genuine organisational commitment replace the current reliance on individual advocacy and managerial goodwill, Lived Experience supervision will remain inadequate, and the distinct epistemology that makes lived experience transformative will continue to be eroded.

Limitations:

This study’s limitations include recruitment primarily through professional networks. This likely over-represented Lived Experience workers who already have access to supervision and the capacity for advocacy. Participants were concentrated in New South Wales, Victoria, and South Australia; therefore, the findings may not fully apply to other states with different system structures or integration histories. No Aboriginal and/or Torres Strait Islander participants were recruited despite efforts. This is a significant gap given the vital need for culturally safe supervision for Aboriginal and/or Torres Strait Islander Lived Experience Workers.

Including the experiences of supervisors and organisational decision-makers could offer a more complete view of the structural factors at play. Qualitative analysis showed that many participants used the term "supervision" interchangeably with administrative line management, within the data collection tools.

Because of this, data regarding supervision frequency and tenure should be interpreted with caution. The support participants described often did not reflect the discipline-specific reflective practice intended by the term.

Declarations

Competing interests

There are no competing interests.

Funding

This study was completed as part of the Doctor of Philosophy. No external funding was provided for this study.

Author Contribution

LH conceptualised the design of the study, developed the ethics approval. LH and SW analysed the data. All Authors contributed to the review of the manuscript. All the authors have read and approved the final manuscript.

Acknowledgement

The authors would like to thank the Lived Experience workers who provided their time, energy and resources to complete this study. Lead author would also like to thank Amy Smith who has provided ongoing supervision and guidance supporting the work.

Data Availability

The qualitative data (interview transcripts and demographic information) underlying this study are not publicly available to protect the privacy and confidentiality of participants. This research involved in-depth interviews with Peer Workers about their personal lived experience supervision experiences. Given the sensitive nature of these disclosures and the relatively small, identifiable workforce, sharing raw data could compromise participant anonymity. This study was approved by the University of New England Human Research Ethics Committee (HE-2025-2212-4448) and conducted in accordance with the National Statement on Ethical Conduct in Human Research (NHMRC, ARC, Universities Australia, 2023). Reasonable requests regarding the data may be directed to the corresponding author at the University of New England.

References

1. Byrne, L., Roennfeldt, H., Wolf, J., Linfoot, A., Foglesong, D., Davidson, L., & Bellamy, C. (2021). Effective peer employment within multidisciplinary organizations: Model for best practice. *Administration and Policy in Mental Health and Mental Health Services Research*. https://doi.org/10.1007/s10488-021-01162-2
2. Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L., Castles, C., Craze, L., & Saunders, M. (2021). *National Lived Experience Guidelines*. National Mental Health Commission.
3. Cao, Y., Hancock, N., Honey, A., Scanlan, J. N., Glover, H., Povolny, A., Govindasamy, S., Smart, G. L., & Ahmadpour, N. (2026). Trauma informed participatory design: definitions, practices and resources. *Codesign*. https://doi.org/10.1080/15710882.2026.2659838
4. Castles, C., Stewart, V., Slattery, M., Bradshaw, N., & Roennfeldt, H. (2023). Supervision of the mental health lived experience workforce in Australia: A scoping review [Journal Article Review]. *International Journal of Mental Health Nursing*. https://doi.org/10.1111/inm.13207
5. Chreim, S., Dobrowolski, J., Wan, A., & Da Silva, E. A. (2026). Mental health peer support workers' experiences and management of interpersonal boundaries: A scoping review and integrative framework. *Social Science & Medicine*, *399*, 119117. https://doi.org/10.1016/j.socscimed.2026.119117
6. Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research*. Josey-Bass.
7. Cousins, C. (2025). Supervision and Support for the Lived Experience Peer Workforce. *Australian Counselling Research Journal*, *Vol 18:2*, 10–16. https://www.acrjournal.com.au/resources/assets/journals/Volume-18-Issue-2-2025/ACRJ-Vol-18-Issue-2.pdf
8. Edwards, J. P., Spagnolo, A. B., Cronise, R., Enders, G., Forbes, J., & Pratt, C. (2026). Peer Support Supervision Competencies: Results of Participatory Action Research. *Community Ment Health J*. https://doi.org/10.1007/s10597-026-01612-x
9. Fair Work Ombudsman (2025, September 4). Pay guide - Social, Community, Home Care and Disability Services Industry Award [MA000100] (Effective 1 October 2025). Australian Government.
10. Foglesong, D., Spagnolo, A. B., Cronise, R., Forbes, J., Swarbrick, P., Edwards, J. P., & Pratt, C. (2022). Perceptions of Supervisors of Peer Support Workers (PSW) in Behavioral Health: Results from a National Survey. *Community mental health journal*, *58*(3), 437–443. https://doi.org/10.1007/s10597-021-00837-2
11. Halverson, K. L. (2026). A Three-Dimensional Approach to Narrative Analysis. *International Journal of Qualitative Methods*, *25*, 16094069261430196. https://doi.org/10.1177/16094069261430196

12. Hodge, L., Pearce, T., Jackson, B., & Wayland, S. (2026). Models of Supervision Relevant To Peer or Lived Experience Workforce Within Mental Health: A Scoping Review. *Community mental health journal*. https://doi.org/10.1007/s10597-025-01581-7
13. Jorgenson, J., & Schmook, A. (2014). *Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention* https://mhanational.org/wp-content/uploads/2025/02/Enhancing-Peer-Provider-Workforce.pdf
14. Kilpatrick, E., Keeney, S., & McCauley, C. O. (2017). Tokenistic or genuinely effective? Exploring the views of voluntary sector staff regarding the emerging peer support worker role in mental health [Journal Article]. *Journal of Psychiatric and Mental Health Nursing*, *24*(7), 503–512. https://doi.org/10.1111/jpm.12391
15. Lara, E. I., Bond, L., O'Neill, K., Ruiz, E., & Patel, V. (2026). Peer with a P versus a p: A mixed-methods study of peer support training, service delivery, and supervision across global contexts. *PLOS Mental Health*, *3*(1), e0000447. https://doi.org/10.1371/journal.pmen.0000447
16. National Health and Medical Research Council, Australian Research Council & Universities Australia. (2019). *Payment of participants in research: Information for researchers, HRECs and other ethics review bodies*. Commonwealth of Australia.
17. Norton, M. J. (2025). *Peer Support Work in Mental Health Services: Theory, Research, Policy and Practice*. Routledge.
18. O'Brien, B. C., Harris, I. B., Beckman, T. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: a synthesis of recommendations. *Academic Medicine*, *89*(9), 1245–1251. https://doi.org/10.1097/acm.0000000000000388
19. Repper, J., Aldridge, B., Gilfoyle, S., Gillard, S., Perkins, R., & Rennison, J. (2013). *Peer Support Workers: a practical guide to implementation*. http://centreformentalhealth.org.uk/wp-content/uploads/2018/09/ImROC_briefing7_Peer_Support_Workers_implementation.pdf
20. Reeves, V., Loughhead, M., Halpin, M. A., & Procter, N. (2024). Do I feel safe here? Organisational climate and mental health peer worker experience. *BMC health services research*, *24*(1), 1255. https://doi.org/10.1186/s12913-024-11765-8
21. Robinson, S., & Isaacs, A. (2025). Roles, responsibilities and role challenges of lived experience workers in a regional mental health service: a qualitative study. *Advances in Mental Health*, *23*(3), 395–409. https://doi.org/10.1080/18387357.2024.2436404
22. Ser, H. X. E., Pua, X. Y. V., Li, Z., & Goh, Y. S. (2024). Experiences of Certified Peer Support Specialist Providing Formal Peer Support in Mental Health Services: A Systematic Review and Meta-Synthesis. *International journal of mental health nursing*, *33*(6), 1988–2004. https://doi.org/10.1111/inm.13415
23. Shaw, S., Shirley, L., Schroeder, E., Thompson, G., Watt, K., & Forsyth, K. (2026). A systematic review of the barriers and facilitators to lived experience involvement in mental health services. *Front Public Health*, *13*, 1737709. https://doi.org/10.3389/fpubh.2025.1737709
24. Victorian Department of Health (2023). *Workforce initiatives: lived and living experience workforces (LLEWs)*. https://www.health.vic.gov.au/workforce-and-training/lived-experience-workforce-initiatives
25. Watson, E., Bowyer, D., Cooper, S., Dodd, Z., Manning, E., Morgan, G., Owen, D., Repper, J., Repper, P., & Szmit, D. (2024). *Supervision of Peer Workers*. https://static1.squarespace.com/static/65e873c27971d37984653be0/t/66b3443087061575857165 63/1723024432598/ImROC+Briefing+Paper+25+%2

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- floatimage1.png