DISCUSSION PAPER: POWER, RISK, AND THE ROLE OF THE LIVED AND LIVING EXPERIENCE WORKFORCE

PURPOSE

This paper explores how power dynamics between clinical staff and the Lived and Living Experience Workforce (LLEW) influence the assessment and management of risk in mental health and alcohol and other drug (AOD) settings. It presents key reflections from the LLEW and clinical staff to inform collaborative approaches to shared risk, dignity of risk, and person-centred care.

The insights in this paper have been gathered at the LLEW and Clinical Staff Collaboration Forum on 14th May 2025 which was organised by the NEMHSCA and EMHSCA LLEW Working Group members.

How this paper can be used in practice

- Prompt team discussions and reflective practice on power and risk.
- Guide policy and procedure reviews to better include LLEW perspectives.
- Inform joint training and workforce development for clinicians and LLEW.
- Support codesign of care planning tools and risk approaches with consumers, carers, and LLEW.

1. POWER DYNAMICS AND RISK: WHAT'S HAPPENING NOW?

The relationship between clinicians and peer workers is deeply shaped by organisational structures, cultural norms, and professional hierarchies—especially when conversations turn to risk.

Key Themes Identified

- **Clinical authority dominates final decisions**: In most settings, clinicians retain ultimate responsibility for risk-related decisions, with legal frameworks reinforcing this position.
- **Feeling silenced or excluded**: Peer workers often report feeling their contributions are not valued—particularly when discussing suicide, medication, or safety concerns. This diminishes opportunities for truly collaborative care.
- **The "protection" narrative**: Clinicians may exclude peers from risk conversations under the guise of protecting them, reinforcing unequal power dynamics.
- **Peer perspectives seen as "less professional"**: LLEW are often seen as "fragile" or "vulnerable", which can lead to their insights being overlooked—even when their lived expertise is critical.
- **Structural and systemic barriers**: Risk-averse policies, resourcing gaps, and models of care rooted in the medical model further entrench power imbalances.
- **Shifting the culture**: Some services are shifting the culture toward shared approaches, but these remain the exception rather than the norm.

"The lived experience perspective is often the bottom rung of the ladder when it comes to decisions about risk."

2. WHAT ROLE SHOULD PEER WORKERS PLAY IN RISK MITIGATION?

There is strong consensus that peer workers **do contribute to risk mitigation**—but in ways that differ from clinical practice. Their role is often under-recognised or inconsistently supported.

What Peers Bring

- **Mitigating risk through relationship**: Storytelling, trust-building, and presence can de-escalate distress and support meaning-making.
- **Amplifying the person's voice**: Peer workers help ensure that consumers are heard and respected, especially in times of crisis.
- **Holding space, not holding risk**: Many LLEW naturally assess risk but prefer to explore rather than control it, avoiding checklist-driven interactions.
- **Contextualising distress**: LLEW can interpret risk differently, seeing shades of grey where clinical models may frame things in black and white.

"Peers just care about the person in front of them. Rather than "assessing risk or mitigation". Listening to their story tends to mitigate risk. Always assessing in this way."

Systemic Gaps

- **Inconsistent expectations and scope**: Peers are often unsure what they can or can't do regarding risk—and so are their teams.
- **Lack of clarity around disclosure/reporting**: It remains unclear what peer workers must report, and what can remain confidential within their scope.
- **Training and support needs**: Peers need tailored support (e.g. alternative to suicide training, reflective practice, peer-informed supervision) to participate confidently in risk-related work.

3. WHAT COULD A SHARED RISK APPROACH LOOK LIKE?

A shared approach to risk places the **consumer at the centre**, values **multiple perspectives**, and makes decisions **collaboratively**.

Principles of Shared Risk

- **Dignity of risk**: Consumers have the right to take risks and make decisions about their lives, even when those decisions challenge clinical comfort zones.
- **Collaboration, not containment**: Risk should not be the responsibility of one role—effective care requires shared understanding and joint planning.
- **Transparency and trust**: Open, ongoing conversations between clinicians, LLEW, consumers, families, and carers are essential.

- **Role clarity and mutual respect**: Knowing each other's boundaries, skills, and limitations enables safe and ethical collaboration.

"It looks like working together collaboratively, understanding the value of the different perspectives everyone brings, whilst holding the person at the centre of it all."

Practice Examples

- **Open Dialogue**: Multi-stakeholder conversations where everyone, including the person and their network, contributes to shared understanding.
- **Joint planning**: Clinicians and LLEW co-develop safety or care plans, with the consumer leading where possible.
- **Reflective practice spaces**: Regular forums where clinicians and peers debrief and learn together.

4. THE RISKS OF BEING TOO RISK-AVERSE

A singular focus on avoiding harm can unintentionally **cause harm**—to the person, the relationship, and the system as a whole.

What We Might Lose

- **Autonomy and growth**: When people aren't allowed to make choices, they lose opportunities for learning, self-determination, and healing.
- **Trust and connection**: Risk-driven responses can rupture therapeutic relationships and lead people to disengage from services entirely.
- **Human rights and dignity**: A risk-averse system can inadvertently strip people of their agency and reinforce trauma.
- **Professional and systemic stagnation**: Services may fail to innovate, adapt, or learn if risk avoidance trumps recovery-oriented care.

"We can't protect people from everything—it's unrealistic and paternalistic."

Opportunities for Change

- **Clarify roles and responsibilities** around risk for all staff, including peer workers.
- **Review policies** to align with shared risk principles, dignity of risk, and integrated care.
- **Invest in joint training and reflective practice**, especially involving LLEW and clinical teams together.
- **Adopt co-designed planning tools** that include perspectives from clinicians, LLEW, consumers, and families/carers.
- **Strengthen supervision and debriefing supports** across all disciplines.

DISCUSSION QUESTIONS

1. What needs to change in your service or team to enable more balanced decision-making around risk?
2. How might we better include and support Peer Workers in risk-related conversations?

3. What would a shared risk model look like in your setting, and what would help bring it to life?
4. How can we ensure dignity of risk is upheld, without compromising duty of care?