# Submission to the Review of the National Mental Health and Suicide Prevention Agreement

A Response to the Productivity Commission's Interim Report from Consumers of Mental Health WA

31/07/2025

Consumers of
Mental Health WA

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# 1. Acknowledgement of Country

Consumers of Mental Health WA proudly acknowledge Aboriginal people as Australia’s First Peoples and the Traditional Owners and Custodians of the Land and Water on which we live and work. We acknowledge Western Australia’s First Nations’ communities and culture and pay respect to Aboriginal Elders past, present and emerging.

We recognise that Sovereignty was never ceded and the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on First Nations communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of First Nations Peoples to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

# 2. Preamble

## 2.1 About the Respondents

Consumers of Mental Health WA (CoMHWA) is Western Australia's peak body for and by mental health consumers (people with a past or present lived experience of mental health issues, psychological or emotional distress). We are a not-for-profit, systemic advocacy organisation independent from mental health services that exists to listen to, understand and act upon the voices of consumers. We work collaboratively with other user-led organisations and a diversity of stakeholders to advance our rights, equality, recovery and wellbeing.

## 2.2 Request for Feedback

CoMHWA works to uphold the dignity and human rights of consumers, through providing advocacy in leading change with and for consumers. We appreciate notification of the outcomes of our submission to this consultation in order to understand and communicate the difference made through our work.

Please provide feedback via the contact details on this submission's cover page.

## 2.3 Language

CoMHWA uses the term mental health 'consumer' throughout this submission. Mental health consumers to refer to people who identify as having a past or present lived experience of psychological and emotional distress, irrespective of whether they have received a diagnosis of mental illness or accessed services. Other ways people may choose to describe themselves include "peer", "survivor", "person with a lived experience" and "expert by experience".

This definition is based on consumers' call for respect, dignity and choice in how we choose to individually identify. As individuals we choose different ways to name and describe our experiences that may confirm or trouble ideas about 'mental illness'.

CoMHWA endorses Black Dog Institute's Aboriginal and Torres Strait Islander Lived Experience Centre's universal definition of lived experience for First Nation communities:

A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander peoples' ways of understanding social and emotional wellbeing.

This definition recognises that there are fundamental differences to how Aboriginal and Torres Strait Islander people experience and define mental health challenges and suicide compared to mainstream definitions.

# Executive Summary

As Western Australia's peak body representing the collective voice of people with a lived experience of mental health challenges, Consumers of Mental Health WA (CoMHWA) are pleased to be able to respond to the Productivity Commission's (PC) Interim Report on their Review of the National Mental Health and Suicide Prevention Agreement (NMHSPA). We appreciate the Productivity Commission's direct and earnest assessment of the failings of the Agreement and the space they have made for people with Lived Experience to help guide the development of a new Agreement going forward.

The following submission hopes to build upon the findings and strengthen the recommendations outlined in the PC's Interim Report, and help shape this critically important opportunity to enact change on a national level.  CoMHWA believes that strengthening the Peer Workforce and embedding lived experience meaningfully into all levels of service delivery are central to the larger task of shifting the culture around mental health support—by promoting non-discriminatory practices when working with consumers within clinical settings and in the sector more broadly.

CoMHWA also strongly believes that the Review of the NMHSPA provides a key opportunity to address the enduring gap in psychosocial supports that continues to impact nearly half a million Australians who would benefit from these community-based programs.  We have accordingly proposed that the Review of the NMHSPA should include provisions for increased funding to existing psychosocial support programs, as a path to providing much needed assistance to consumers while a new Agreement is drafted and co-designed.

Ensuring that next Agreement is developed through true co-design with people with Lived Experience will help ensure that the goals of the Agreement reflect real needs, and address concerns heard from people who find themselves navigating the landscape of mental health support regularly. While we recognise the importance of including carers and people with a Lived Experience of suicide in co-design, CoMHWA hopes that the PC will understand that the voices of those people with a Lived Experience of mental health challenges are a distinct group, who should be central to the process of shaping the system that directly impacts their lives.

# 3. Response to Interim Report Recommendations

### Draft Recommendation 2.1 - Deliver key documents as a priority

By the end of 2025, the Australian Government should publicly release:

- the National Stigma and Discrimination Reduction Strategy
- detailed National Guidelines on Regional Planning and Commissioning that meet the needs of primary health networks and local hospital networks

### CoMHWA Response

CoMHWA offer our **full support** to the above recommendation

### Draft Recommendation 4.1 - Developing a renewed National Mental Health Strategy

A National Mental Health Strategy is needed to articulate a clear vision, objectives and collective priorities for long-term reform in the mental health system over the next 20–30 years. The National Mental Health Commission should oversee the development of this Strategy and undertake a co-design process with people with lived and living experience, their supporters, families, carers and kin.

The National Mental Health Strategy should take account of the objectives and actions included in the National Suicide Prevention Strategy, which was released in early 2025.

The next National Mental Health and Suicide Prevention Agreement should include actions governments will take over the agreement's term that are aligned with the long-term objectives articulated in the strategies.

### CoMHWA Response

CoMHWA offer our **full support** to the above recommendation

### Draft Recommendation 4.2 - Building the foundations for a successful agreement

The current National Mental Health and Suicide Prevention Agreement, including funding commitments, should be extended until June 2027, to give sufficient time to develop the foundations of the next agreement and renew the National Mental Health Strategy.

To support the next agreement:

- the National Mental Health Commission should run a co-design process with people with lived and living experience, and their supporters, families, carers and kin to identify relevant and measurable mental health and suicide prevention objectives and outcomes
- the Department of the Prime Minister and Cabinet should convene negotiations with the support of the National Mental Health Commission, and facilitate engagement between the Australian, state and territory governments on their shared priorities
- commitments and actions intended to improve collaboration across all government portfolios should be included in the main body of the agreement rather than a separate schedule. Governments should allocate dedicated funding for collaborative initiatives and enablers of collaboration
- the Australian Institute of Health and Welfare should lead the development of a nationally consistent set of outcome measures for mental health and suicide prevention. Implementation plans to develop any

new indicators should be in place within 12 months of the agreement being signed.

### CoMHWA Response

CoMHWA offer our **partial support** to Draft Recommendation 4.2, and strongly urge the Productivity Commission to consider amending this recommendation to include:

- As an I**nterim measure**, whilst the new agreement is finalised and a co-designed, integrated and fit for purpose psychosocial support program is able to be implemented, the Commission should call for **current funding** for existing psychosocial supports provided through programs such as the Commonwealth Psychosocial Support Program (CPSP) and Information, Linkages and Capacity Building (ILC) grant program and State/Territory funded psychosocial support programs to be **doubled**.
- It is CoMHWA's position that an extension in time of existing programs does nothing to address the current unmet needs and simply pushes the problem further down the line. The number of people needing support will only increase over the time, without additional supports, as demonstrated in the change between the Productivity Commission's Inquiry Report into Mental Health (2020) and the Analysis of Unmet Need report (2024). **A failure to act now is often the biggest failure of all.** A co-design process with people with Lived Experience with a broader scope than simply informing the measurable outcomes and objectives for the Agreement.

### Draft Recommendation 4.3 - The next agreement should have stronger links to the broader policy environment

The next agreement should articulate its role within the policy environment and specify the way it links with other key policy documents. This will require consideration of the interactions with a range of policy areas including housing, justice, disability supports and more. As a starting point, the next agreement should link to:

- the National Health Reform Agreement, which provides much of the funding for the mental health and suicide prevention system
- key policies in relevant non-health portfolios, such as the Better and Fairer Schools Agreement which will support the whole-of-government approach needed to improve mental health and suicide prevention outcomes (draft finding 4.1)
- jurisdictional mental health and suicide prevention policy documents, which should inform the bilateral schedules developed under the agreement
- policy documents related to Aboriginal and Torres Strait Islander social and emotional wellbeing, including the National Agreement on Closing the Gap (draft recommendation 5.1)

### CoMHWA Response

CoMHWA offer our **full support** to the above recommendation **however** encourage the Productivity Commission to consider strengthening this recommendation with a call for a **cross-portfolio review of social determinants** from federal, state and territory governments.

### Draft Recommendation 4.4 - Governments should immediately address the unmet need for psychosocial supports outside the National Disability Insurance Scheme

The Australian, state and territory governments need to immediately agree to responsibilities for psychosocial supports outside the National Disability Insurance Scheme. State and territory governments should be responsible for commissioning services and commence work to address the unmet need.

The next agreement should:

- confirm the roles and responsibilities for psychosocial supports and the funding split between the Australian, state and territory governments
- include Australian Government funding to the state and territory governments to help cover the shortfall in support
- include a detailed plan and timeline for the expansion of services, with the aim of fully addressing the unmet need by 2030.

### CoMHWA Response

CoMHWA offer our **full support** to the above recommendation and further suggest that the Lived Experience workforce should be **explicitly named** as a critical feature of the plan for expanding and future services.

## Draft recommendation 4.7 - The next agreement should support a greater role for people with lived and living experience in governance

The Australian, state and territory governments should address barriers to the effective involvement of people with lived and living experience in the governance of the next agreement. This should include limiting the use of confidentiality agreements with lived and living experience representatives, opening greater opportunities for communication between lived and living experience working groups, other working groups and the senior officials group, and appropriately remunerating lived experience representatives.

The makeup of governance forums for the next agreement should be reconfigured to ensure:

- adequate representation of people with lived and living experience at each level of governance
- balanced representation between people with lived and living experience of mental ill health and lived and living experience of suicide
- governance roles for carers commensurate with the significant role they play in Australia's mental health and suicide prevention system.

The next agreement should articulate formal roles for the two recently established national lived experience peak bodies in its governance arrangements. These bodies should be adequately resourced to fulfill these roles.

### CoMHWA Response

CoMHWA offer our **partial support** to the above recommendation, and strongly encourage the following amendments to be adopted by the Productivity Commission:

- The proposal to ensure 'balanced representation' of Lived Experience voices between those with a lived experience of suicide, and those with a lived experience of mental health challenges, **risks diluting the rights-based perspective of mental health consumers** with other cohorts more sympathetic to clinical models of care.
- Groups developed to offer Lived Experience governance should be comprised so that **consumers are the predominant voice** in this process. An equal apportionment of places for carers and consumers risks minimising the impact of consumer voices, which have

traditionally more aware of the limitations of clinical services and emphasised the need for fundamental system change.

- The articulation of **formal roles for** the nationally established **Lived Experience peak bodies** should be extended to support similar peaks that are already operating in states and territories.
- States and territories without appropriate Lived Experience peaks should be supported to establish these as a matter of urgency.

**Draft recommendation 4.8 - A greater role for the broader sector in governance**

The next agreement should support a greater role for service providers and the broader mental health and suicide prevention sectors in governance. Both mental health and suicide prevention providers should take part in governance mechanisms.

### CoMHWA Response

CoMHWA offer our **partial support** to the above recommendation, and urge the Productivity Commission to consider the following changes:

- The increased involvement of service providers and broader sector representation in the governance of the Agreement should not dilute opportunities for input from Lived Experience Expertise into governance processes going forward. We seek **equitable not equal representation** of Lived Experience in governance, which would not be facilitated by a simplistic equality of spaces between consumers with Lived Experience on the one hand, and multiple service providers, clinical bodies, and Lived Experience perspectives from Carers on the other.

**Draft Recommendation 4.12 - Funding should support primary health networks to meet local needs**

The next agreement should emphasise national consistency in areas where there are efficiency gains, including standardising reporting requirements across primary health networks (PHNs) and jurisdictions where possible and investigating ways to standardise procurement and data collection processes.

Funding arrangements in the next agreement should provide PHNs with sufficient flexibility to commission locally relevant services or support existing services where they have been positively evaluated. National service models should not limit the ways in which PHNs meet their communities' needs.

### CoMHWA Response

CoMHWA offer our **partial support** to the above recommendation, noting the following amendment for the Productivity Commission to consider:

- The recommendation should include advice to **review the practice of PHN commissioning** services with inefficient short-term funding cycles which cause discontinuity and confusion for consumers as well as uncertainty for service providers, and their staff, in planning, delivering and just as importantly, improving their programs for consumers.

## Draft recommendation 4.13 - The next agreement should support the implementation of the National Mental Health Workforce Strategy

The next agreement should support the implementation of the National Mental Health Workforce Strategy. This should include:

- clear commitments to, and timelines for, priority actions under the National Mental Health Workforce Strategy
- an explicit delineation of responsibility and funding for workforce development initiatives.

### CoMHWA Response

CoMHWA offer our **full support** to the above recommendation

## Draft Recommendation 4.14 - The next agreement should commit governments to develop a scope of practice for the peer workforce

The next agreement should commit governments to develop a nationally consistent scope of practice for the peer workforce, in consultation with the peer workforce, that:

- promotes safer work practices for peer workers
- contributes to better outcomes for people accessing mental health and suicide prevention peer support
- improves public understanding of the profession, allowing for greater recognition of peer workers' capabilities and contributions

### CoMHWA Response

CoMHWA offer our **partial support** to the above recommendation, and believe that the admirable goal of this measure could be further supported by the following inclusion:

- The recommendation should include requirements for **mandatory levels of funding** to support the development of the **Peer Workforce** and require respective governments in the Agreement to **commit to a 500% increase** in the size of their peer workforces over the period of the next agreement.

## Draft recommendation 5.1 - An Aboriginal and Torres Strait Islander schedule in the next Agreement

The next agreement should include a separate schedule on Aboriginal and Torres Strait Islander social and emotional wellbeing. This schedule should be developed in a process of co-design with Aboriginal and Torres Strait Islander people.

The schedule should:

- align with the National Agreement on Closing the Gap and other important documents and include tangible actions, with commensurate funding, to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people, including better mental health and suicide prevention outcomes
- clarify governance for its design and implementation, including the role of the Social and Emotional Wellbeing Policy Partnership established under the National Agreement on Closing the Gap as the

decision-making forum over issues relating to Aboriginal and Torres Strait Islander social and emotional wellbeing

- measure progress in a strengths-based way, with community-led evaluation
- articulate and embed priorities highlighted by community such as cultural safety in all services, and greater investment in the community-controlled sector and the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce

**CoMHWA Response**

CoMHWA offer our **full support** to the above recommendation, and encourage the Productivity Commission to additionally consider:

- Taking steps to understand and address the **complex intersection of kinship systems and cultural protocols** for First Nations peoples when developing this schedule through comprehensive co-design.
- **Data sovereignty** so that information collected through community evaluation is stored and owned by those people that have provided it.
- Requiring all funded programs to adopt the principles of the Gayaa Dhuwi Implementation Plan

# 4. Discussion

The following section outlines in further detail some key inclusions and changes outlined above that CoMHWA would like to see applied to the Interim Report's draft recommendations. Our responses are not exhaustive and touch upon only those recommendations that we feel are appropriate to provide feedback on. CoMHWA notes that submissions from other consumer peaks such as the National Mental Health Consumer Alliance provide detailed responses to some recommendations that we do not address such as 4.11, and we offer our support to their suggested changes in lieu of simply replicating these arguments below.

## 4.1 Strengthening Draft Recommendations

**Draft Recommendation 4.2 - Building the foundations for a successful agreement**

CoMHWA partially endorses the Productivity Commission's Draft Recommendation 4.2 and believe that this blueprint for a revised Agreement could be strengthened by addressing two key points outlined below.

Firstly, CoMHWA wishes to highlight the delimited scope of co-design proposed within the recommendation. 4.2 notes that co-design would address the content of the NMHSPA only in relation to 'measurable outcomes and objectives' for the Agreement. CoMHWA strongly supports a process of co-design with people with a Lived Experience that encompasses **all aspects** of the

NMHSPA. Restricting this process to the measurable outcomes and objectives for the Agreement represents an unnecessary limitation that is incongruent with the scope and meaningful depth proper to true co-design.

Secondly, CoMHWA believes that the proposed extension of the NMHSPA to 2027 must *not* prevent the government from providing a critically important increase in funding for existing programs under the current Agreement. As noted in the 2024 report *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme*, there are an estimated 493,640 people that require psychosocial support that are not receiving this support through either the NDIS or through other government-funded programs.[1] Outside of this cohort, 263,100 are considered to have a ‘moderate mental illness’, and 230,500 were classified as having a ‘severe mental illness’.

This significant gap in the provision of psychosocial support is of paramount concern for CoMHWA and our members. We strongly urge the Productivity Commission to stipulate that additional interim funding be allocated to address this gap in psychosocial support. CoMHWA believes that the nearly half a million people without psychosocial support should not have to wait for a new Agreement in order to get the help that they need now. We accordingly encourage the PC to consider amending recommendation 4.2 to include advice that the following Commonwealth initiatives should receive additional funding:

- **Commonwealth Psychosocial Support Program** – The current budget allocation of 272.1 million dollars for the Commonwealth Psychosocial Support Program[2] should be **doubled** over the next 12-month period to 544.2 million dollars, to help address psychosocial gaps until a new Agreement is finalised.
- **Information, Linkages and Capacity Building Program** – The Department of Social Services Information, Linkages and Capacity Building (ILC) Program should also have the current 364.5 million dollar budget[3] allocation **doubled** to 729 million dollars.
- **State and Territory Funded Programs** – The State and Territory-funded programs identified in the *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme* that provide psychosocial support, should be featured in a

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[1] Health Policy Analysis (2024). *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme*. https://www.health.gov.au/sites/default/files/2024-08/analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme-final-report.pdf

[2] Australian Government. (2025). *Commonwealth Psychosocial Support Program*. Department of Health, Disability and Aging. https://www.health.gov.au/our-work/commonwealth-psychosocial-support-program

[3] Australian Government. (2025). *Reform of the Information, Linkages and Capacity Building Program*. Department of Social Services. Reform of the Information, Linkages and Capacity Building Program | Department of Social Services

recommendation advising that their **funding should be doubled** to address the immediate gaps in support.

The Productivity Commission has an opportunity in the review of the NMHSPA to provide a much needed and long overdue boost to psychosocial supports across the country. We wish to commend the work undertaken by the Productivity Commission previously in their *Mental Health Inquiry Report* from 2020, where the gap produced in psychosocial support from the introduction of the NDIS was first recognised and estimated.[4] We note, however, that the *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme* report estimates that the number of people classified as having severe mental health challenges, who do not have appropriate psychosocial support is **76,500 (16%) higher** that the Commission's figure.[5] This change is due to an increase in the prevalence of people experiencing severe mental health challenges, and the increasing severity levels of people not receiving psychosocial supports outside the NDIS. CoMHWA is hopeful that a new Agreement can help facilitate the development of fit-for-purpose foundational supports and other planned psychosocial support systems. However, the widening of **this gap in psychosocial supports** outlined above **speaks to the urgency** required to ensure that the nearly half a million people currently languishing without support options have their needs addressed now, prior to the development of the revised NMHSPA.

## Draft Recommendation 4.7 - The next agreement should support a greater role for people with lived and living experience in governance

CoMHWA supports the PC's draft Recommendation 4.7, however we believe that this could be strengthened by including a call for Australian federal, state and territory governments to address barriers to the effective involvement of people with lived and living experience in the governance of the next agreement. Examples of barriers that could be addressed include limiting the use of confidentiality agreements with lived and living experience representatives, which can prevent awareness of systemic issues and subsequent advocacy to address these problems. We would also like to see a strategy to promote greater opportunities for communication between lived and living experience working groups, other working groups, and groups of senior officials within institutions. We additionally note that it is important to ensure that those Lived Experience representatives

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[4] Productivity Commission. (2020), Mental Health, Report No.95, Canberra. p. 862 https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf

[5] Health Policy Analysis (2024). *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme*. p. 78 https://www.health.gov.au/sites/default/files/2024-08/analysis-of-unmet-need-for-psychosocial-supports-outside-of-the-national-disability-insurance-scheme-final-report.pdf

involved with governance are appropriately remunerated, either through dedicated FTE or along NMHC guidelines[6] to recognise the value of their contributions.

While CoMHWA is strongly in support of a **greater role in the Agreement for people with a lived experience of mental health challenges**, we note a concern about the proportional representation of lived experience outlined in the second point of the above draft recommendation. Though we recognise the importance of including people with a lived and living experience of suicide, CoMHWA feels that it is critical to acknowledge the predominance of family and carer perspectives within this cohort—in particular, we hold concerns over the tendency of these perspectives to adopt a **'risk averse' approach to suicide prevention**. Risk assessment practices in clinical settings are often followed by **suspension of human rights, uncritical and ineffective use of restrictive practices, and incarceration for consumers.**

### Draft recommendation 4.8 - A greater role for the broader sector in governance

While CoMHWA welcomes efforts to combat system fragmentation and address siloing in the mental health sector, we wish to raise a concern about the *extent* to which service providers' perspectives might influence governance under a new Agreement. The importance of ensuring that there is rigorous governance under a future Agreement is paramount, and it is crucial to ensure that provisions developed going forward do not simply recreate the status quo that the Agreement hopes to change. It is CoMHWA's belief that the best drivers of rigorous governance and system change are those people with Lived Experience Expertise, who are proficient in using their knowledge of services and consumer experiences to address high-level concerns about service delivery and achieving meaningful, measurable outcomes.

In light of the above, we seek an *equitable* representation of Lived Experience in governance under the new Agreement. We seek **equitable not equal representation** would not be facilitated by a simplistic equality of spaces between consumers with Lived Experience on the one hand, and multiple service providers, clinical bodies, and Lived Experience perspectives from Carers on the other. Involvement of service providers and other sector representatives in governance practices

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[6] National Mental Health Commission. (2020). *Paid Participation Policy: For people with a lived experience of mental health difficulties, their families and support people.* https://www.mentalhealthcommission.gov.au/sites/default/files/2024-03/paid-participation-policy-2020.pdf

should balance these contributions with increased representation spaces for people with a lived experience of mental health challenges.

### Draft Recommendation 4.12 - Funding should support primary health networks to meet local needs

While CoMHWA broadly supports the above recommendation, we urge the PC to include guidelines in a new Agreement that would prevent the recommendation from leading to an **inefficient cycle of short-term funding** coupled with ad hoc extensions. This caution is drawn from CoMHWA's experience of our own programs experiencing unpredictable cycles of funding. One CoMHWA service, for example, has been funded through the Commonwealth Psychosocial Supports Program. The funding blocks began with a three-year contract, which was extended for an additional year, before having a 3-month and a 9-month extension, and finally receiving another year.

The challenges of this intermittent contractual arrangement impact consumers, who may have to live in **uncertainty** and plan for alternative paths of support, as well as services, who must retain staff and complete the required paperwork/applications, are **inefficient** and unnecessary. This is especially the case for services that have demonstrated their effectiveness. The commissioning of services by PHNs to meet **local needs** should, in CoMHWA's view, seek to break from this practice of short-term funding cycles for proven projects, and allow services the stability to retain staff and innovate on their practices.

### Draft Recommendation 4.14 - The next agreement should commit governments to develop a scope of practice for the peer workforce

CoMHWA supports the above recommendation to develop a scope of practice for the Peer Workforce, however we believe that there is an opportunity for the PC to deliver a more robust recommendation to ensure that the Peer Workforce achieves the **maximum impact for consumer**s. Simply put, the PC should recommend that there should be **mandatory** levels of funding made available for the hiring of peer workers in all clinical and non-clinical services, but most importantly, for psychosocial supports in the community.

The PC should set **quantifiable targets** for the growth of the Peer Workforce tied to this mandatory funding. Given the comparative youth of peer work as a discipline, and the inordinate, cost-effective benefits it offers to the provision of holistic mental health care, CoMHWA believes that a new Agreement should commit to a **500% increase** in this workforce over the next five years.

**Draft recommendation 5.1 - An Aboriginal and Torres Strait Islander schedule in the next Agreement**

CoMHWA supports the PC's recommendation to develop a separate schedule for Aboriginal and Torres Strait Islander Peoples in the new Agreement. We do, however, note that Western Australia has a **diverse kinship system and complex cultural protocols**. This nuance needs to be embedded from the start of the process of codesign for this schedule. We wish to raise the importance of finding the correct collection of people to comment from an Aboriginal perspective, as it relates to the various country and kinship groupings in WA.

CoMHWA also notes that, in order for Aboriginal mental health consumers to be able to appropriately engage in processes that "measure progress in a **strengths-based** way, with community-led evaluation", data needs to be returned in a culturally safe manner to the communities from which it is gathered. Aboriginal peoples' **data sovereignty and self-determination needs** to be incorporated into the co-design processes to close the loop and help support self-determination.[7]

## 4.2 Gaps in the Interim Report

In this section we outline some of the issues that we feel the PC did not address in the Interim Report, outlining our rationale for addressing these concerns and the alignment of their impact with the system improvement sought under a new NMHSPA.

### Funding Models must be Reviewed to Ensure Long Term Support

- CoMHWA believes that the current funding landscape for services limits their impact and results in system-wide inefficiencies

CoMHWA strongly believes that funding models for mental health and suicide prevention services, as well as psychosocial supports, need to be rethought to support long term investment. The experiences of our members and knowledge of the sector lead us to recognise that current funding

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[7] Milroy, H., Kashyap, S., Collova, J., Mitchell, M., Derry, K. L., Alexi, J., Chang, E. P., & Dudgeon, P. (2022). Co-designing research with Aboriginal and Torres Strait Islander consumers of mental health services, mental health workers, elders and cultural healers. Australian Journal of Rural Health, 30(6), 772–781. https://doi.org/10.1111/ajr.12945

Australian Productivity Commission. (2024). Review of the National Agreement on Closing the Gap: Study Report Volume 1. https://www.pc.gov.au/inquiries/completed/closing-the-gap-review/report/closing-the-gap-review-report.pdf P. 63.

approaches all too often lead to successful or promising programs losing support and leading to gross inefficiency. We note that the impact of this approach to funding was recognised by the PC in their 2020 Inquiry in Mental Health:

> *"…funding for other services such as psychosocial supports is fragmented and based on short contract cycles, which make it harder to deliver quality services on a continuous basis to people"*[8]

CoMHWA believes that grants for mental health services and programs must avoid being awarded through grants that stipulate the funding to be 'once off', or that have time limits for the continuation of programs. This leads to circumstances where a program might be developed through thorough and intensive processes such as co-design, but then is only funded for a few years before stopping due to factors such as the grant allowing for no extensions. For example, a successful Information, Linkages and Capacity Building (ILC) grant might be funded for 2 or 3 years, but then has to cease as there are conditions on these grants and no ongoing funding options tied to successful impact. No matter how well that program may have worked, or how much it provided evidence about being value for money, the funding approach used means you are excluded from reapplying to an ILC grant for the same program.[9]

## Pilot Programs must Receive Ongoing Funding if Successful

- CoMHWA advises that pilot programs should have ongoing funding arrangements in place, tied to the achievement of outcomes for a respective pilot, to ensure that programs that work are supported rather than squandered

Pilot programs to deliver mental health care, and especially community-based psychosocial supports, must be supported to continue if their pilots have achieved their impact and outcomes after evaluation. CoMHWA strongly believes that the Agreement can address this by stipulating that **pilot programs that demonstrate success must not face barriers to acquiring continued funding**. All too often, we hear of valuable programs and services that are established with great effort and deep consultation with the community, that demonstrate their impact, but have their funding moved away into alternative pilots aiming to address different gaps in the system.

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[8] Productivity Commission. (2020). Mental Health. Report no. 95, Canberra. p. 55 https://www.pc.gov.au/inquiries/completed/mental-health/report

[9] Australian Government. (2024). *Funding for Disability Projects*. Department of Social Services. https://www.dss.gov.au/funding-disability-projects

Building rapport and trust in communities takes time and effort, and the loss of pilot funding means that these valuable connections with the community are also lost. This leaves service users without the particular kind of support offered through the program, and promulgates an atmosphere of distrust and cynicism about new services generally in the community.

## The Fragmented Landscape of Services requires Dedicated Supports

- CoMHWA notes the PC's recognition of the fragmented landscape in which mental health services operate. We believe that dedicated funding to support service navigation and individual advocacy are required to address this barrier.

CoMHWA would like to see the new Agreement take a clear position that promotes the provision of freely available options for consumers to be able to access advocacy, as well as supports that provide service and system navigation.

Our members have frequently reported that they face consistent **difficulty in finding appropriate supports** in the ever-changing landscape of service provision. The effectiveness of the current system would be enhanced by addressing this barrier in service awareness. CoMHWA has experienced ongoing demand for and positive feedback about our **Peer Pathways program**, which provides tailored, up-to-date information about services to people based on their particular needs and circumstances. We have heard repeatedly from our members that they often are not aware of the services available to them in their community, and creating a straightforward pathway to learn about appropriate supports would result in benefits for both consumers and those services that they can be linked in to.

It is also critically important to ensure that consumers have access to **advocacy services**, which are well placed to address unintended oversights or system gaps that emerge from the complex interplay of services, policies and other institutions in the mental health landscape. In the Western Australian context, we have heard consistently from consumers that the capacity to be supported through individual advocacy is severely limited from both Government services such as Mental Health Advocacy Service (MHAS) and NGOs such as the Health Consumers Council (HCC). Our Individual Advocacy program at CoMHWA has had demand sufficient to close waitlists three times over the past 12 months, reflecting the broader landscape where the demand for individual advocacy from consumers comprehensively outstrips the capacity of the sector to provide it.

### Dedicated Funding for Lived Experience-Led Research

- CoMHWA believes that the much-needed widespread adoption of the Peer Workforce has been hampered by a lack of appropriate research into the discipline. Making a recommendation to explicitly fund Lived Experience-led research into peer work would help to address the systemic barriers peers face and promote system-wide culture changes in how Lived Experience is viewed.

The adoption of the Peer Workforce would be strengthened by **dedicated funding being made available for Lived Experience-Led research**. The current landscape of mental health and suicide prevention support is presently still clinically dominated, with biomedical science remaining the received view about what kind of help people experiencing mental health distress or contemplating suicide should receive. Developing a comprehensive base of research for peer work, designed and led by Lived Experience but operating within the epistemological standards of traditional research methodologies, will help to expedite the expansion of the peer work discipline by providing clear, evidence-based rationale for services—particularly clinical services—to incorporate peer workers going forward.

It is critical to ensure that people with a Lived Experience of mental health challenges help to design the research into peer work and other non-clinical alternatives to the traditional biomedical approach. Simply put, current research practices tend to focus on quantitative outcomes and can neglect qualitative methodologies that are better able to capture the experiences of consumers in services. Stipulating requirements for **Lived Experience-Led research** in a recommendation from the NMHSPA review would help to ensure that studies and evaluations of peer work are conducted in a timely and thorough manner to support the expansion of this discipline.

# 5. Requests for Information

## 5.1 Lived Experience Governance

**Information request 4.2**

The PC is seeking examples of barriers to the genuine participation and influence of people with lived and living experience in governance forums. How could successful inclusion and engagement of people with lived and living experience in governance be measured?

CoMHWA identifies the following barriers to genuine participation and influence of people with lived and living experience in governance forums.

1. Lack of funding and designated Full Time Equivalent (FTE) roles within decision-making agencies or organisations for lived experience governance.
2. Lack of organisational readiness for Lived Experience designated roles, including a lack of psychosocial safety for lived experience experts. For example, internal education for the organisation concerning the role and purpose of lived experience within governance and the role and purpose of peer work as a separate discipline.
3. Lack of clarity about the role and purpose of lived experience, including adequate working definitions of "Lived Experience Expert".
4. Established workplace cultures that include the stigmatisation of people with significant mental health challenges as less capable of governance than those who have been trained through traditional methods. This includes a defensiveness concerning the inclusion of lived experience at all levels of management when it comes to information sharing.

In order to embed lived experience fully within the mental health system, value must be placed on the experience of people who have had experience of mental health challenges. A key factor influencing the value afforded to Lived Experience expertise relates to clarifying that this is a distinct kind of experience with the mental health system: an experience which causes an existential shift in life as a person has previously understood it, changing it so significantly that they must reimagine and redefine themselves, their place in the world and the horizon of their future plans.

Lived experience expertise is missing in major areas of the policy cycle. Currently, the role of lived experience in policy formulation is often limited to broad input into forums such as "consumer consultation" prior to the policy drafts, or feedback on narrow questions after a draft has been created. There are also contributions at the evaluation phase, where we are asked "what worked" or "what didn't work". This positions mental health consumers as outside stakeholders simply offering feedback, rather than allowing lived experience expertise to work in partnership within traditional decision-making systems to shape services that are intended to support them.

For lived experience expertise to be utilised to its full capacity, we must have designated roles and consultation forums within all stages of the policy cycle. This means that FTE resources must be allocated within all the spaces of the policy cycle for lived experience experts to contribute on an equal basis.

The NMHSPA is uniquely placed to lead a policy shift towards creating more fit-for-purpose models of care. One of the first actions should be creating positions for lived experience experts within the

National Mental Health Commission, including but not limited to a National Mental Health Lived Experience Co-Commissioner that has equal standing and institutional power to the highest level of person informing the conversation from a medical model or traditional policy perspective.

Furthermore, this position should be tasked with, and resourced for, creating auditing measures that can be implemented at a local level, to assist and guide state mental health commissions (or equivalent bodies), as well as with service providers in shifting towards integrating lived experience expertise at a governance level as well as with the provision of peer services.

Some of the strategies that could serve to ensure lived experience governance is implemented and measured accurately might include:

- Design of the consultation mechanism by which mental health consumers could meaningfully contribute to the co-design of community-based and lived experience-led mental health centres.
- Audit current service providers to gain an accurate understanding of current extent of lived experience governance.
- Build education around the potential functions of lived experience in governance such as:
    - Providing oversight around service and staff composition, pay scales of lived experience employees and paid consumer participants;
    - Ensuring that peer and lived experience staff have access to training and professional forums such as conferences; and
    - Oversee standards for the fidelity of authentic co-design and lived experience engagement within the service
- Work with existing national and state consumer representative bodies and movement leaders to identify the particular blocks that are being experienced in lived experience governance within their states.

## 5.2 Integrating the Peer Workforce Successfully in Clinical Settings

**Information request 4.4**

The PC is looking for case studies to highlight best practice in integrating peer workers in clinical mental health and suicide prevention settings, particularly by improving clinician awareness of the peer workforce. Are there examples of best practice that could be adopted in other organisations or settings?

CoMHWA is grateful for the opportunity to expand and give further information on best practice in peer integration in clinical settings. In our previous submission, we highlighted the MIFWA (Mental

Illness Fellowship of WA) Hospital to Home program in which peers walk beside people who are exiting inpatient settings. In this submission we are expanding to highlight three further programs that seek to integrate peers into clinical settings.

### First Step Support (proposed program)

CoMHWA recently commissioned a literature review, undertaken by lived experience consultant Aimee Sinclair, which sought to summarise “**the current evidence on the value of integrating mental health consumer lived experience (peer) specialists into primary health care settings, and the best practices for doing so.**”[10]

The report found that the majority of Western Australians who seek help for their mental health do so through their GP first.[11] Furthermore, GPs may also be in a position to identify drivers of mental and emotional distress related to people's physical health conditions, such as pain or fatigue.[12]

The report scoped a program that would **integrate peer work into the primary health setting**. “The First Step Program” is the provisional name for a program with the overarching aim of enhancing the accessibility and ease of navigation of mental health care by incorporating peer-led supports into the primary health setting at the GP level. The advantages of such a program would be to make peer support available to the majority of people who access mental health supports through their GP and GP-referred specialist services. The report notes that despite the lack of previous application in the Australian context, “the research does suggest that peer workers in GP settings have the potential to support both individual health outcomes and support the work of GPs. Peer workers can support individuals to clarify and prioritise their health needs, facilitate communication and attendance, provide psychosocial and navigational support, cultivate hope and empowerment, build community connections, provide education and resources.”[13]

*For your reference, we have attached the literature review, which provides a comprehensive response to your request for information, as Appendix One in this report.*

### Peer Work Positives (currently being delivered)

Peer Work Positives is a training program undertaken by CoMHWA to enhance the visibility of Peers in the sector and improve organisational readiness for successful development of peer work in

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[10] Appendix A, p. vi

[11] *Ibid.* p. ix

[12] *Ibid*.

[13] *Ibid*. p. xxxii

services. Peer Work Positives training has been delivered face-to-face and online and is targeted at non-Peer health service providers. The training focuses on how organisations can address the unique challenges and opportunities that come with building a peer workforce. The training is designed to increase organisational confidence in employing peers, through delivering the following content:

- how to have open dialogue about the barriers to employment faced by peer workers
- how to best utilise peer skillsets
- integrating peer work values into existing operations
- how to manage peer workers supportively, emphasising the importance of including line supervision channels
- tips about the recruitment and retention of peer workers.

This training has so far been delivered to a total of 96 individuals, with representatives from 32 different organisations. The largest representation of attendees came from the WA Public Health system, including North Metropolitan Health Service, South Metropolitan Health Service, East Metropolitan Health Service, Child and Adolescent Mental Health Service, & WA Country Health Service. Anglicare WA and Homeless Healthcare also organised specific dates for their teams to receive this education. Outside of government and community health organisations, there have also been attendees from private practices and the education sector.

Attendees identified that they left this course with a clearer understanding of the role of peer work and how it is delivered, and the difference between having a lived experience and working in a 'Lived Experience' role. Attendees also reported that the long-term impact of the training was that their organisations had increased the quantity of consumer representation and employed peer workers. These outcomes reveal that there are genuine opportunities to facilitate the adoption of peer workers in clinical settings by ensuring that there is comprehensive education about the role, scope and purpose of peer work.

**Neami and 'Co-creating safety with consumers' program (program in pilot)**

CoMHWA also wish to highlight the innovation currently underway in the mental health sector by Neami National in relation to rethinking traditionally ineffective and traumatic risk assessment processes through their 'Co-creating safety with consumers'[14] program.

CoMHWA have heard from members that are involved in the pilot stages of this program, who have relayed that the new process has led to a dramatic improvement in the experience of consumers

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[14] Neami National. (2025). *Co-creating Safety with Consumers*. https://www.neaminational.org.au/news-and-stories/co-creating-safety-with-consumers/

engaging with the service, in this case a Step-Up Step-Down facility. While the specific details of this program are currently publicly unavailable, the development of a person-centred and trauma-informed approach to addressing risk management in clinically governed spaces represents a critically important step in fundamentally rethinking clinical practices that have been shown to be ineffective and harmful to consumers.

CoMHWA understands that Co-creating Safety involves creating tailored approaches to mapping out how consumers may react when unwell in a service, and, working together, create a plan for both staff and service users about the best way to manage such distress. This approach replaces the traditional crude, clinical risk assessments that result in a numerical value determining whether a person needs to be escalated into an Emergency Department or other (often traumatic) clinical response pathways.

# Appendix A - First Step Support: A literature review on the evidence for mental health lived experience (peer) workers in primary health care settings

***Authored by Aimee Sinclair, Lived Experience Researcher and Consultant***

***Commissioned by Consumers of Mental Health WA***

## Acknowledgement of Country

The author recognises the Whadjuk people of the Noongar Nation as the traditional custodians of the land upon which this report was written. This always was, and always will be, Aboriginal land. Consumers of Mental Health WA proudly acknowledge Aboriginal people as Australia’s First Peoples and the Traditional Owners and Custodians of the Land and Water on which we live and work. We acknowledge Western Australia’s First Nation’s communities and culture and pay respect to Aboriginal Elders past, present and emerging.

We recognise that Sovereignty was never ceded and the significant and negative consequences of colonisation and dispossession on Aboriginal communities.

Despite the far-reaching and long-lasting impacts of colonisation on First Nations communities, Aboriginal people remain resilient and continue to retain a strong connection to culture. We acknowledge the strong connection of First Nations Peoples to Country, culture and community, and the centrality of this to positive mental health and wellbeing.

# Definitions

This review uses the following language, noting that many of these terms are contested in various spaces and communities.

| | |
|---|---|
| Primary care setting | A setting where individuals first access healthcare services within their community. This review focuses on general practice (GP) when discussing primary care settings, however primary health care settings may also be community health centres, pharmacies, or allied health practices. Primary care settings do not require a GP referral. |
| Secondary care setting | A setting that provides specialised medical or social support provided by specialists after referral by a primary care physician. These include mental health specialists and programs. |
| Consumer<br>Service user<br>Patient | Reflecting Australian mental health policy, this report predominantly uses the term consumer to signify those who access (both voluntarily and involuntarily) mental health services within secondary care settings.<br>This term distinguishes those who primarily access mental health services from those who primarily support others accessing mental health services (such as carers/family members/kin).<br>In primary health care, the equivalent term often used by GPs is 'patient'. In some secondary care settings, 'service user' is used. When summarising existing literature, we have predominantly used the same language as adopted within the literature.<br>We acknowledge these terms are political, and individuals who access services will have different preferences on how they prefer to identify.<br>The term consumer/survivor is an important identifier within the consumer/survivor movement, for those who have survived marginalisation and systemic oppression within the mental health system and whom share experiences of social, cultural, and legal discrimination, harmful myths, severe socioeconomic and health disadvantages, violence, and abuse (Centre for Mental Health Nursing, University of Melbourne, 2025). |
| Consumer perspective | This report adopts the definition of consumer perspective as outlined in the Victorian Mental Health Consumer Lived Experience Workforce Discipline Framework (2025, p.7):<br>"A perspective acquired through accessing services within the mental health system. It is based on a belief that individual consumers are 'the experts' about their own life and carry the wisdom to best articulate their own needs when accorded the time, space and means to do so. It is an idea that developed out of a collective consciousness and political solidarity that grew from the consumer/survivor movement and provides a way of looking at the world from the point of view of a group that has been marginalised and discriminated against." |
| Service provider | An individual or organisation that provides health care services, including general practitioners. |
| Lived experience (peer) work/ers | Reflecting the WA Lived Experience (Peer) Workforces Framework, this review uses lived experience (peer) work/ers to refer to a specific discipline and designated roles that actively use personal lived experience of distress, |

| | |
|---|---|
| | crisis and/or service use and consumer perspective to support others and/or transform mental health systems and services. Lived experience (peer) work encompasses a broad range of roles from frontline peer support roles, through to policy, advocacy, and research roles.<br>Whilst recognising lived experience (peer) work encompasses both consumer and carer perspectives, this review focuses only on consumer perspective lived experience work.<br>Lived experience roles are distinguished from clinical roles by the use of lived expertise and experiential knowledge gained through experiences of diagnosis, service use, and personal recovery (Centre for Mental Health Nursing, University of Melbourne, 2025). |
| Peer support workers<br>Peer specialists | The review uses the term peer support worker or peer specialist to reflect those who work in frontline peer roles, providing relational support. Peer support worker or peer worker is more common in Australia, whilst peer specialist is more commonly used in the US literature. |
| Social prescribing | A system of collaborative referral and prescription that incorporates social models of support and non-clinical interventions such as exercise and activity, diet and nutrition, arts–based therapies, peer support, coaching and mentoring, and employment and welfare support. Social prescribing involves connecting or reconnecting people to their communities, by linking people with new social activities and networks such as book clubs, walking clubs, coffee mornings, gym classes, befriending groups and so forth.<br>A more in-depth description is provided within the report. |
| Collaborative care<br>Integrated care | Collaborative care models typically consist of a multi-professional approach to care, a structured management plan, clinical and non-clinical supports, scheduled follow ups and enhanced inter-professional communication. Integrated care involves the same team approach to primary care, bringing together primary care physicians and allied health practitioners, however it brings them together under the same organisational framework (Isaacs & Mitchell, 2024). |

# Executive Summary

This report summarises the current evidence on the value of integrating mental health consumer lived experience (peer) specialists into primary health care settings, and the best practices for doing so. It was commissioned by CoMHWA as the starting point for further research regarding the viability and efficacy of embedding lived experience (peer) workers within primary health care settings. The overarching aim of the proposed project (provisionally named 'First Step Support') is to enhance the accessibility and navigability of mental health care by introducing peer-led support at the critical first point of contact within GP clinics. The report presents findings and recommendations from a rapid scoping review of peer-reviewed journal articles from 2015 to present regarding peer workers in primary care settings, as well as a more general review of the literature on social prescribing. The review is intended to support decision-making about the potential value of, and barriers to, implementing 'First Step Support'.

## Background

There is strong evidence and policy support for primary healthcare as the optimal location for responding to mental health challenges and avoiding crisis admissions (Royal Australian College of General Practitioners, 2023; WA Primary Health Alliance, 2016). General practitioners (GPs) in particular, are vital to primary mental health care.

Simultaneously, the need to enhance the delivery and quality of mental health supports at the primary health care level has been recognised. GPs report having limited capacity and capability to include mental health care effectively within their clinical practice (Perez & Kidd, 2015; Royal Australian College of General Practitioners, 2022), and consumers report a number of barriers to seeking mental health support within a clinical setting (Cunningham et al., 2023; Spooner et al., 2024; Tabvuma et al., 2022). Responses to mental health challenges within primary care are often limited to medication and/or a referral to psychology or other secondary mental health care supports, leaving socio-economic needs unmet. Further, the demand for secondary mental health care supports currently surpasses availability and many West Australians either face significant wait times and/or have limited access to such supports. Such gaps lead to people seeking help at emergency departments in crisis, and/or worsening physical and mental health conditions (Lawn, Dee-Price, et al., 2024; WA Primary Health Alliance, 2016).

Proposed new models of primary care to overcome these limitations include funding for longer consultations, additional follow-up contact, social prescribing, multidisciplinary teams, and the inclusion of lived experience (peer) workers (Isaacs & Mitchell, 2024; Lawn, Shelby-James, et al., 2024; Perez & Kidd, 2015). The implementation of such approaches remains in the early stages in Australia.

Lived experience (peer) workers, for example, are inaccessible to many within Western Australia, especially for those whose main or only support is through general practice and/or private psychology. As far as can be known, mental health peer workers are yet to be co-located with GPs in primary health care settings within Western Australia, despite strong policy support (RACGP, 2023; WAPHA, 2024). Existing research shows that lived experience (peer) workers bring a unique ability to relate to and validate the experiences of others, building trust and providing effective support in decision making and care planning, as well as providing consumer perspective to clinicians to improve practice (King & Bender Simmons, 2018). Working together, GPs and peer specialists provide complementarity skills and knowledge between professional knowledge of medical conditions (e.g., diagnosis, treatment options, and delivery) and experiential knowledge of navigating distress, systems, and recovery. As such, the potential of co-locating lived experience (peer) workers within GP settings is an area worthy of further exploration.

## Approach

A rapid scoping review of the peer-reviewed academic literature and high-quality grey literature was undertaken to identify what is known literature about the potential effectiveness, and barriers to effectiveness, of mental health lived experience (peer) work in primary care settings, with a focus on those seeking mental health support for the first time, and where social prescribing is involved.

## What did the review find?

The review identified nine peer-reviewed articles relevant to the research objectives. Most articles evaluated programs within the USA and looked specifically at implementation enablers and barriers. These articles provide relevant information to guide the development and implementation of a potential pilot project in WA.  Two articles focused on outcomes. Formal evidence for the value of peer workers within GP settings is weak, however this is due to the emerging state of peer workers in primary care settings, and does not reflect potential value. The PS-PC intervention, currently being evaluated by Lawn et al. (2024) in Australia with results soon to be published, will potentially provide the most useful information to guide a pilot program in Western Australia. An informal review of the academic and grey literature on integrated care and social prescribing suggest these approaches have the potential to align well with the use of lived experience (peer) workers in primary care settings. The small number of studies suggest the integration of peer workers in general practice settings is an innovative approach worthy of further exploration.

## Summary of recommendations

1. Appropriate funding should be sought for progressing the First Step Support proposal. Given that integrating lived experience (peer) workers into GP settings aligns closely with WAPHA’s current mental health strategy and with primary health network policies more broadly, WAPHA would be an ideal funding partner.

2. As outlined in CoMHWA’s First Step Support project brief, and building on the findings from this review, further input into the development of a potential pilot should be gathered from consultations with GPs and consumers at a local level, to ensure the development of a pilot program is contextualised to a WA setting. Also recommended is further input from lived experience (peer) workers involved in social prescribing initiatives in NSW and QLD, as well as lived experience (peer) workers co-located in other primary care settings. Such consultation should not replace pre-implementation and implementation facilitation when integrating lived experience (peer) workers into specific GP clinics.

3. Given the PS-PC intervention most closely resembles the First Step Support project proposal, learnings from this intervention, whether through publication or further documented meetings with the evaluators, should inform future steps.

4. Given the innovative and emerging nature of integrating peer workers into primary care settings, CoMHWA should consider partnering early with an appropriate research team to evaluate the pilot and publish findings for a broader audience, as well as to support future scaling up.

5. Social prescribing has the potential to align well with lived experience (peer) work within a primary care setting, and should be considered as one aspect, among many, of a peer worker role within GP settings. Careful consideration needs to given to ensuring social prescription does not compromise lived experience (peer) values.

6. Further consideration, taking into account local context and demand,  should be given to whether a pilot should include, prioritise, or exclude individuals who are not seeking mental health supports for the first time.

A table is provided in section 4 that outlines more specific recommendations regarding the logistical and operational aspects of integrating peer workers into GP clinics.

## Structure of the review

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|---|---|
| Section 1: Background | provides background to the 'First step support' project proposal and literature review. |
| Section 2: Methodology | describes the methodology of the literature review. |
| Section 3: Findings | outlines the findings of the literature review. In describing potential models, some parts of this section draw on information that sits outside of the formal scoping review to meet the research objectives. |
| Section 4: Discussion and Recommendations | provides a discussion of the findings, and the implications for future planning. A set of recommendations is provided to guide future development of lived experience (peer) work in primary care settings. |
| Appendix | Provides details of the articles and findings from the scoping review. |

# Section 1: Background

This literature review was commissioned by Consumers of Mental Health WA (CoMHWA) as part of a broader project, looking to inform the design and implementation of a pilot program to embed mental health consumer lived experience (peer) workers within general practice (GP) clinics. The objective of the pilot, provisionally named ‘First Step Support’ is to provide lived-experience support and service navigation to individuals engaging with mental health care for the first time, ensuring that people can access timely, compassionate, and effective mental health support. The literature review contained within this report is one part of the project being undertaken to inform the design and implementation of First Step Support. This section outlines some of the issues and ideas that underpin the project proposal.

## Why focus on primary care settings and GPs?

There is strong evidence and policy support for primary healthcare, and more specifically GPs, as the optimal location for responding to mental health challenges (Isaacs & Mitchell, 2024; Royal Australian College of General Practitioners, 2023; WA Primary Health Alliance, 2024).

Whilst some primary care options for early intervention mental health support exist outside of general practice clinics in Australia (for example, Headspace or Medicare Mental Health Centres), GPs are predominantly the first point of contact for individuals seeking mental healthcare, with practitioners reporting that 71% of issues discussed with GPs relate to psychological issues (Royal Australian College of General Practitioners, 2022). GPs are the principal referrers for more targeted mental health support through secondary care, however the primary care setting also provides opportunity to work with people who are not willing to seek specialised mental health support (Blixen et al., 2015), or are more likely to engage through primary care settings rather than referral to mental health services (Bartels et al., 2004). Most mental health services in Australia are delivered by GPs and in certain circumstances, a GP may be the only point of care for individuals who require mental health support (Royal Australian College of General Practitioners, 2022). According to the RACGP (2020), the vast majority of Australians feel their GP always or often spends enough time with them and always or often shows respect, and listens carefully. A long standing positive relationship between an individual and their GP makes it more likely that emotional struggles will be raised during a consultation (McMorrow et al., 2022; Parker, Byng, Dickens, Kinsey, et al., 2020).

Further, there is a well-established bi-directional relationship between physical and mental health challenges which makes GP settings an important target for an improvement to mental health responses (Calder et al., 2022; Ee et al., 2020; Happell et al., 2016; Thorburn, 2024). Mental health challenges that present in primary care are rarely present in isolation. Individuals diagnosed with a mental illness experience poorer physical health and have higher rates of early death due to preventable physical illness (Campion, 2019; Firth et al., 2019; Gronholm et al., 2021). Contributing factors include discrimination, social disadvantage, trauma, effects of psychiatric medication and poor access to preventative health care (Firth et al., 2019).

Concurrently, physical health conditions can lead to significant emotional and mental distress. The importance of integrating physical health care for people living with a mental health diagnosis has been recognised through the Equally Well National Consensus Statement, which provides national, cross-sector support for integrated mental health and physical health care. Through general practice, individuals receive both mental health and physical health care, unlike many other secondary or primary mental health settings.

Identifying and responding appropriately to mental health struggles in their early stages within a primary care setting reduces the reliance on emergency departments and specialised secondary supports, aligning with government policy and consumer preferences towards early intervention and community-based care (Kaleveld et al., 2020; WA Primary Health Alliance, 2016).

## What limitations to recovery-orientated mental health support currently exist within GP settings?

Whilst GPs are vital to primary health care, there are several barriers to responding effectively in a primary care setting in ways that align with a recovery-orientated and human rights-based approach.

Firstly, GPs report having limited capacity and capability to include mental health care effectively within their clinical practice (Perez & Kidd, 2015; Royal Australian College of General Practitioners, 2022). Reported barriers include limited consultation times, limited formal training, lack of resources, poor organisational support, increasing levels of complexity and severity of presentations, and tensions between medical and social determinants (Cunningham et al., 2023; General Practice NSW, 2013; Parker, Byng, Dickens, Kinsey, et al., 2020; Tabvuma et al., 2022; WA Primary Health Alliance, 2022). These barriers, alongside the responsibility placed on GPs, can lead to a high risk of burnout and psychological distress, suicidal thoughts, and substance abuse (Beyond Blue, 2019; Parker, Byng, Dickens, & McCabe, 2020).

GP consultations represent a massive investment in time, buildings, facilities, and training, yet remain a relatively blunt use of time. Examples specific to mental health include an underutilisation of data (e.g. when the patient has not been supported to complete paperwork or assessments prior to the consultation), underutilising the learning moment (e.g. providing information or exploring options in a pressured environment with little time for reflection often results in both the GP and the patient failing to take much in) and underutilising patient, family member and community expertise and agency (e.g. reinforcing expectations that the clinician is the expert and fixes all problems) (Horne et al., 2013). The limited amount of time in consultations, and complexity of mental health challenges means that GPs often resort to risk assessments (which have little underpinning evidence) or structured responses to avoid complexity and the stress of not knowing how to help (Parker, Byng, Dickens, & McCabe, 2020).

Responses to mental health challenges within primary care are thus often limited to medication and/or a referral to psychology or other secondary mental health care supports (General Practice NSW, 2013). Neither response is highly effective. The demand for such secondary supports currently surpasses availability and many West Australians either face significant wait times and/or have limited access (WA Primary Health Alliance, 2022). Such gaps lead to people seeking help at emergency departments in crisis, and/or worsening physical and mental health conditions (Lawn, Dee-Price, et al., 2024). Further, many individuals seeking mental health care within a primary care setting do not follow through with the referral or drop out of supports prematurely (Mott et al., 2014; Ranney et al., 2024).

Responses that rely on medical interventions alone are also not in line with the addressing the well-established links between social and emotional wellbeing (Patel et al., 2023). Whilst pharmaceutical responses to distress can reduce symptoms for some people, the evidence is mixed, with limited efficacy in some situations, and significant iatrogenic effects to some treatments. As such, there have been calls to reduce the rates of over-prescription for some psychiatric medications in Australia (Wallis et al., 2021, 2025). Pharmaceutical responses do not address the socioeconomic, physical, relational, and environmental factors that can both lead to, and sustain, mental health challenges, as well as the impact that distress can have on these factors (for example, work absenteeism, loss of housing). Social determinants of health thus require thinking outside of traditional clinical approaches and require a variety of skills that address social drivers of mental health struggles, recognise the expertise of individuals seeking support and their family/carers/kin, and draw on community strengths and supports.

Whilst many individuals have good relationships with their primary care provider, others seeking mental health support at a primary care setting experience barriers to access. Such barriers include potential stigma and discrimination, a lack of understanding and validation in clinical settings, the hierarchal nature of the patient/doctor relationship, a medical model that does not fully consider social determinants, diagnostic overshadowing, and a lack of trauma informed care (Cunningham et al., 2023; General Practice NSW, 2013; Spooner et al., 2024; Tabvuma et al., 2022; Zirnsak et al., 2024). These barriers are amplified for particular groups in Western Australia including, but not limited to, LGBTQIA+, rural and regional, Aboriginal and Torres Strait Islanders, young people, people with disabilities, older adults, culturally and linguistically diverse communities, and people facing homelessness (Consumers of Mental Health WA, 2024; WA Primary Health Alliance, 2024; Youth Pride Network, 2024). Epistemic injustice continues to exist within health care, and is particularly an issue for those seeking mental health support, given that mental health care has traditionally been structured around paternalistic notions of capacity and coercive treatment (Daya, 2022; LeBlanc & Kinsella, 2016; Newbigging et al., 2024).

However, there is increasing overall recognition within primary care of the importance of collaborative decision making and recovery orientated care that recognises the expertise of individuals seeking support and their families/carers/kin. When individuals are supported to be partners in their care, better health outcomes are delivered (Royal Australian College of General Practitioners & Consumers Health Forum of Australia, 2020).

Such approaches require a shift within a patient-GP relationship where power, expertise and agency are shared, and consultations are collaborative, with the health provider bringing professional and clinical expertise, support and navigation, and the individual bringing personalised information on their illness and its effects; knowledge about their lifestyle; their willpower, motivations, goals and aspirations (Horne et al., 2013).

Whilst GPs are often well informed of these issues, and many attempt to address such barriers and enablers in their daily practice, such approaches are not well supported or recognised by funding mechanisms and structures, thus often implemented in ad-hoc and superficial ways with significant costs to the GP (Horne et al., 2013; Royal Australian College of General Practitioners & Consumers Health Forum of Australia, 2020).

For example, one of the proposed solutions to improve primary mental health care has been mental health integrated care, sometimes referred to in the literature as co-located care or collaborative care, whereby mental health specialists and/or case managers work collaboratively with GPs as part of a multi-disciplinary team (General Practice NSW, 2013; Isaacs & Mitchell, 2024). Collaborative care has been shown to improve mental health physical outcomes for individuals and there are increasing calls for this approach to be expanded within Australia (Isaacs & Mitchell, 2024). Recognising the importance of collaborative care, the vast majority of general practices across Australia have practice nurses, and just over half have allied health professionals or other specialists (Isaacs & Mitchell, 2024). However, despite the known potential of these models of care, integrating mental health care within the primary care setting has been fraught with challenges due to a lack of system and funding changes (Isaacs & Mitchell, 2024). Similarly, there are increasing policy calls for a focus on social prescribing, yet a lack of system and funding changes is yet to see this implemented well across primary care settings in Australia (Royal Australian College of General Practitioners & Consumers Health Forum of Australia, 2020).

## Lived experience (peer) work

Lived experience (peer) work provides a potential solution to barriers to quality mental health care within GP settings, aligning with both integrated care and social prescribing approaches. In Western Australia, reflecting national and international trends, lived experience (peer) work is increasingly a key part of interprofessional mental healthcare teams. Whilst yet to be utilised in GP settings in WA, consumer lived experience mental health workers exist in WA, and more broadly across Australia, across other settings and contexts as diverse as emergency departments, inpatient units and outpatient clinics, online/digital spaces, suicide prevention and postvention, primary care mental health specific settings (Headspace, Medicare mental health centres, community NGOs), within NDIS funded services, education, policy development, and advocacy. Peer workers are also employed in WA in organisations and government departments supporting women's health, sexual health, alcohol and other drugs, community legal centres and child protection. Peer workers have also proved useful in primary and secondary care teams for facilitating management of chronic physical health conditions (Bates et al., 2008; Lawn, Dee-Price, et al., 2024; Simpson et al., 2024; Watkins et al., 2020).

Lived experience (peer) workers have significant lived experience of a health condition or caring for someone with a health condition, social challenges (eg. discrimination, colonisation, housing insecurity) and/or share social identities and are intentionally employed to use such experience to support others and/or transform systems and ways of working (Byrne et al., 2021). In WA mental health settings, peer workers are guided by the WA lived experience (peer) workforce framework (Mental Health Commission WA, n.d.), which outlines guiding principles of human rights, mutuality, humanity, diversity, authenticity and connection.

Lived experience (peer) work encompasses a variety of roles and tasks, individualised to each situation and context, but may involve education, advocacy, therapeutic support, social prescription and navigation, facilitation of peer support groups, wellness coaching or support. Whilst most thought of as working one-one with individuals providing peer support, 'walking alongside' someone on their recovery journey, it is important to recognise that much peer work also occurs through educating other health professionals and the general community, and advocating for improved services and supports. Such work is not a new idea or practice, particularly in informal community settings, however, its value has increasingly become recognised and thus implemented in formal systems with strong policy support in Australia.

The value of integrating lived experience (peer) workers in specialised mental health settings and other community contexts is well established within the research and supported within Australian policy at both a national and state level. Existing research suggests that peers improve individual health outcomes, influence social determinants of health, lower healthcare costs and address shortcomings in health care related to inequities and fragmentation of services through improving access and continuity of care across health and community settings (King & Bender Simmons, 2018; Lawn, Dee-Price, et al., 2024; Panaite et al., 2024; Viking et al., 2022). Lived experience (peer) workers support a re-framing of individuals from passive recipients of healthcare to active healthcare partners, ensuring human rights regarding informed choice and supported decision making are upheld within healthcare settings. Lived experience (peer) work fosters understandings of mental health challenges or distress that go beyond medical understandings and responses, leading to more individualised, compassionate and holistic responses beyond medication or psy-therapies.

What is less well known, is the potential value of peer workers in facilitating mental health support in primary care settings, particularly GP settings, particularly where individuals are seeking support for the first time. Similarly, the barriers and enablers to integrating peer workers in secondary mental health settings, including maintaining peer work fidelity, are well established (Byrne et al., 2016, 2019; Byrne & Roennfeldt, 2024; Edan et al., 2021; Ibrahim et al., 2019), yet how these barriers and enablers potentially translate to a GP setting is less known, as is the alignment between social prescribing, integrated care, and lived experience (peer) work. Given the potential value that lived experience (peer) workers may bring to GP settings, based on existing research in other areas, this is an area worthy of further exploration.

## Policy context

There is strong policy support for the integration of lived experience (peer) workers in GP settings. At a national level, The Royal Australian College of General Practitioners (RACGP) position statement on mental health care in general practice states that “where possible, mental health professionals, including mental health nurses, *peer support workers* and carers, should be embedded within general practice to encourage strong communication between practitioners, facilitate a ‘no-wrong-door’ approach to mental health for patients, and allow for more effective use of each practitioner’s time and skill” (Royal Australian College of General Practitioners, 2023, p. 1 emphasis added). The Department of Health has an expectation that primary health networks (PHNs) “support models of practice that incorporate peer workers as specialised members of multidisciplinary teams providing person-centred, recovery-oriented and trauma-informed stepped care in mental health and suicide prevention services” (Department of Health (Australia), n.d.). At a state level, the WA Primary Health Alliance (WAPHA) has committed to, as part of its current mental health strategy, to “support the development of a lived experience peer workforce in primary care settings” (WA Primary Health Alliance, 2024, p. 3).

# Section 2: Methodology

The following section outlines the methodology adopted for the literature review.

## Objective

The aim of the literature review, as set by CoMHWA, was to:

- Identify the potential value of peer support in enhancing mental health care in primary care settings (anticipated outcomes for service recipients and providers), with a focus on providing support to individuals seeking mental health support for the first time, and the impact of social prescribing.
- Identify best practice regarding the embedding of peer support in primary care settings, including the barriers and enablers to integration and with consideration for peer support fidelity.
- Explore potential models that demonstrate effective, compassionate approaches to mental health care that go beyond traditional medical treatments.

The overall research question guiding the review was thus:

What is known from the existing literature about the potential effectiveness, and barriers to effectiveness, of mental health peer work in primary care settings, specifically for those seeking mental health support for the first time, and where social prescribing is involved?

## Method

The review was driven by a pragmatic intention to trial the co-location of mental health peer support workers in primary care settings within a WA context. As such, a rapid scoping review of the academic peer-reviewed literature was prioritised, looking for potential benefits and exploring best practice models, with the intention of using the findings to inform a potential pilot program. The aim of the review was not to look for gaps in the research nor evaluate the existing research, and therefore a full systematic review was not deemed necessary. Further, the project timeframe and resources meant a full systematic review was unfeasible. Scoping reviews are useful for areas where there is little research, where quality assessment is not the focus, and where the research needs to be summarised and disseminated to policy makers, practitioners and consumers (Arksey & O'Malley, 2005).

Given the existing academic literature was limited, and there are significant barriers to publishing from consumer perspectives (Jones et al., 2021; Rooney, 2023), high-quality grey literature was also searched for alongside the peer-reviewed literature. Reviewing the grey literature enables inclusion of pilot evaluations, program reports and related analyses and sector guidance on peer work and primary care that may not be reported in the published peer-reviewed literature.

In addition to the scoping review, a much more informal review of the literature on social prescribing was undertaken given this did not arise within the scoping review but was important to CoMHWA's objectives. The author also reviewed relevant policy documents from within the Western Australia setting to determine the implications of findings and recommendations. Finally, the author consulted informally with two peer workers involved with social prescribing initiatives within Australia, one former peer worker co-located within a primary sexual health clinic, and met with team members involved with the evaluation of the PS-PC intervention.

## Inclusion Criteria

The following criteria needed to be met for articles to be included in the review:

- Published or available in English language
- Published during or after 2015
- Program delivered in a high-income country
- Involved consumer lived experience peer work
- Mental health as the primary concern (programs or evaluations that targeted physical health as the primary concern were excluded)
- Face to face supports, as opposed to virtual/internet based
- Delivered within a primary care setting in collaboration with GPs

Thesis, newspaper articles and opinion pieces were excluded.

## Search strategy & study selection

An initial search of the peer-reviewed academic literature involved a broad title and abstract search of databases Proquest, CINHAL, and PsycINFO using the keyword strategy outlined below. The search was conducted in April 2025.

| | |
|---|---|
| Peer work | "peer support*" OR "peer work" OR "peer specialist" OR "lived experience work" OR "peer integration"  AND |
| Primary care | “primary care" OR "primary healthcare" OR "general practice" OR "family physician" OR "primary care-mental health" AND |
| Mental health | “mental” |

All identified citations were collated and uploaded into Zotero reference manager. Duplicates, theses, and newspaper articles were removed. The records were then screened for relevance in two stages: abstract and full text. Abstracts were initially screened for relevance to the project, filtering out those not applicable to the aims of the review, primarily through assessing the abstracts using the inclusion criteria. A second more in-depth screening of the full text was then undertaken. One study, published in 2015, was eliminated because it did not adhere to current acceptable standards regarding evaluation of peer work.

The search was strengthened by identifying relevant articles in reference lists of included articles that were not otherwise identified via electronic search. These articles were retrieved and screened using the same process.

The grey literature was searched using Google search engine and the above search terms.

A summary of the study selection is shown in diagram 1 below.

## Analysis

Details and findings from included articles were extracted using a structured table as included in the appendix. Narrative synthesis was used to identify important patterns and concepts across these studies that met the research objectives.

## Elevating **consumer** perspective

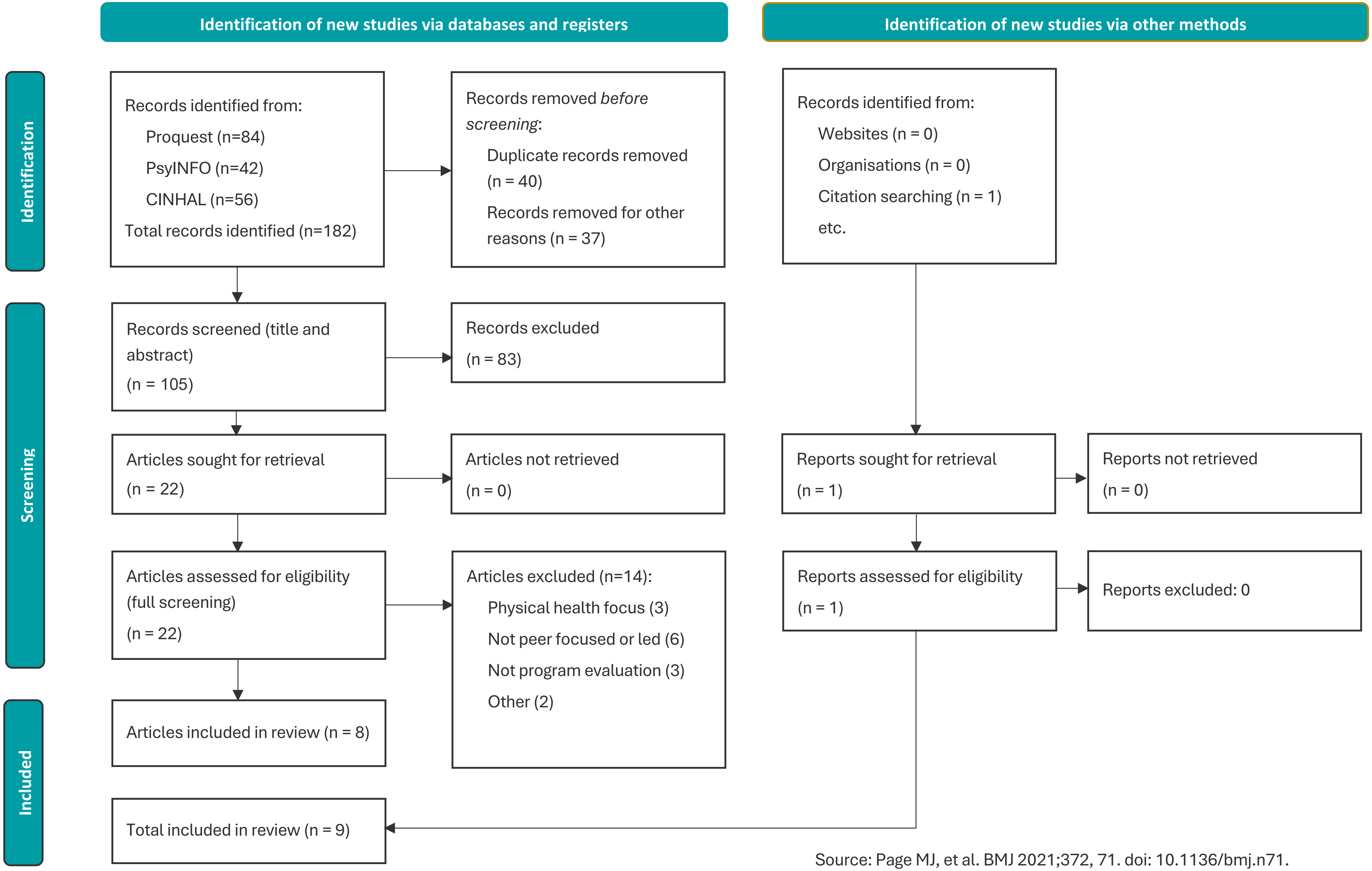
The purpose of CoMHWA is to strengthen and advance the voice, leadership, and expertise of people with lived experience of mental health issues. Such a stance reflects the Convention of the Rights of People with Disabilities, which upholds the rights of individuals with disabilities, including those with a psychiatric diagnosis, to be involved in decision making processes about policies and programs that directly concern them. In line with these rights, the author, who works from a consumer perspective, has aimed to both prioritise the voices and knowledge within the literature of those with lived experience, and highlight where this has been limited. Peer- reviewed academic literature has historically, and continues to, hold bias against the knowledge and experiences of communities and individuals with psychiatric diagnoses, conducting research ‘on’ rather than ‘with’ or ‘led by’ (Sinclair et al., 2023). Unfortunately, much of the literature included in the review did not speak to these biases or limits, and whilst some articles included voices of lived experience as data, it was left unstated in most articles whether individuals with lived experience were included in the research design, analysis or development of implications. As such, the findings must be considered with this in mind, noting that the voices of those with lived experience should always be prioritised in program evaluations.

## Limitations

Limitation of this review include the search and analysis process conducted by a sole researcher, and as stated above, the exclusion of lived experience leadership within included articles. The wide difference in terminology used to describe lived experience (peer) work across contexts also means some articles may have been missed. However, this limitation was minimised given the author is an experienced researcher, well published in lived experience (peer) work, and familiar with international terminology. Reference harvesting identified minimal studies not identified in the electronic searches, further suggesting the likelihood that relevant studies were missed. However, there is similar overlap in some roles, more common internationally, such as “patient navigator” and “community health workers” that may or may not involve the worker having a shared ethnicity, language, socio-economic status and life experiences with the communities they serve, and do similar work to that of what would be expected of a peer worker in a primary care setting (Daniels et al., 2017; Hartzler et al., 2018; Panaite et al., 2024).

In terms of scope, the review was limited to considering the value of consumer peer work focused specifically on those seeking mental health support as the primary reason for seeing a GP. It did not review the literature specifically for carers/family/kin, nor has the review included models or evaluations focused on specific groups navigating intersecting challenges in accessing primary mental health care within a Western Australia setting, including Aboriginal and Torres Strait Islanders, LGBTQIA+ folks, or older adults (WA Primary Health Alliance, 2022). Further thinking and consultation about practices to specifically include these groups are recommended. Given the focus for the overarching project was for those seeking mental health support for the first time, the review also does not specifically focus on supporting individuals navigating chronic mental and/or physical health challenges.

**Diagram 1:**



Identification of new studies via databases and registers

Identification of new studies via other methods

Identification

Records identified from:
Proquest (n=84)
PsyINFO (n=42)
CINHAL (n=56)
Total records identified (n=182)

Records removed *before screening*:
Duplicate records removed (n = 40)
Records removed for other reasons (n = 37)

Records identified from:
Websites (n = 0)
Organisations (n = 0)
Citation searching (n = 1)
etc.

Screening

Records screened (title and abstract)
(n = 105)

Records excluded
(n = 83)

Articles sought for retrieval
(n = 22)

Articles not retrieved
(n = 0)

Reports sought for retrieval
(n = 1)

Reports not retrieved
(n = 0)

Articles assessed for eligibility (full screening)
(n = 22)

Articles excluded (n=14):
Physical health focus (3)
Not peer focused or led (6)
Not program evaluation (3)
Other (2)

Reports assessed for eligibility
(n = 1)

Reports excluded: 0

Included

Articles included in review (n = 8)

Total included in review (n = 9)

Source: Page MJ, et al. BMJ 2021;372, 71. doi: 10.1136/bmj.n71.

# Section 3: Findings

A summary of the findings aligned with the research objectives are provided below. The appendix contains further information on each article included in the review.

## Summary of reviewed articles

Nine articles, all peer-reviewed, were included in the review.

Two articles focused on the benefits or outcomes of integrating lived experience (peer) workers into primary care settings (Lessard et al., 2024; Ranney et al., 2024). Ranney et al (2024) provide a review of existing literature that has evaluated interventions led by peer specialists with the US veteran's health (VHA) primary care system, whilst Lessard et al. (2024) evaluated the effects of integrating a peer support worker into a Canadian primary care clinic. Both models adopt integrative care to certain degrees, with both employing multidisciplinary teams beyond just that of GPs and peer workers. This is an important consideration when reviewing the findings, given that many GP clinics in Western Australia are only staffed by GPs and practice nurses. Whilst only two of the nine articles focused specifically on the benefits or outcomes of integrating lived experience (peer) workers into primary care settings, several of the other articles provided outcomes as a secondary measure.

Six of the nine articles examined implementation or integration of lived experience (peer) workers within primary care settings as their primary objective. All six were from the USA: three from within the VHA system (Chinman et al., 2021; Shepardson et al., 2019; Shook et al., 2024) and three looked more generally at integrated care models (Mayer et al., 2016; Ratzliff et al., 2017; Siantz et al., 2016).

Finally, one article, Lawn et al. (2024) provided an outline of a lived experience peer support intervention for accessing mental health care in a primary care setting, and the proposed methodology for outlining the intervention. Whilst the article does not provide data regarding potential effectiveness or barrier to implementation, it does provide a potential model for consideration, and given this model is being piloted within an Australian setting, it was decided this was an important article for inclusion within the review.

Four of the nine articles involved peer workers within a VHA setting (Chinman et al., 2021; Ranney et al., 2024; Shepardson et al., 2019; Shook et al., 2024). The VHA peer program is the single largest employer of peer specialists in the US, with other 1300 individuals employed as peer specialists (Ranney et al., 2024), and there has been government mandates to ensure such peers are employed within primary care settings. It is therefore unsurprising that much of the literature covered the VHA context. It is important when considering the findings from the VHA model (and several other models evaluated) to note that VHA settings tend to be large clinics with multiple professionals working within the one complex. In Australia, general practices tend to be much smaller, although this is changing to reflect larger clinics (Isaacs & Mitchell, 2024). Further, it has been suggested that peer support in military and veteran populations has unique benefits given the emphasis on unit cohesion, teamwork, and increased trust from having a shared experience of military service that may differ from other populations (Shepardson et al., 2019).

The small number of articles is unsurprising given the relatively new practice of employing peer workers within mental health settings, and more so within primary care settings, which are predominantly more focused on biomedical responses to distress. Lawn et al.'s (2024) trial, for example, is the first in Australia to look at peer workers within a GP setting. It is also possible other programs exist internationally that incorporate lived experience (peer) workers into primary care settings but have not been documented or evaluated.

It was unclear from the articles reviewed whether support was provided to individuals accessing mental health support for the first time. Lessard et al. (2024), however, did find that GPs predominantly referred people with high social needs or recurrent complaints that could not be medically resolved, suggesting the peer specialist may not have been supporting those first accessing mental health supports. The outcomes of Lawn et al.'s (2024) intervention, when published, will be useful in this regard, as they should more clearly speak to whether GPs are likely to refer individuals when first-accessing mental health supports within an Australian context.

No articles mentioned social prescribing. Most literature on social prescribing comes from the UK, and the review did not capture any UK literature. Given social prescribing was of interest to CoMHWA, an informal narrative summary of the social prescribing literature is provided at the end of this section.

There was no grey literature retrieved that matched the inclusion criteria. However, some grey literature was sourced independently of the scoping review to flesh out descriptions of different models and approaches in line with the research objectives.

## Anticipated outcomes

**Objective 1:**
Identify the potential value of peer support in enhancing mental health care in primary care settings (anticipated outcomes for service recipients and providers), with a focus on providing support to individuals seeking mental health support for the first time, and the impact of social prescribing.

The inclusion of peer support within a VHA primary care setting produced significant improvements in at least one main health outcome, including a decrease in alcohol use, PTSD, depressive and anxiety symptoms and overall improvements in health, stress and recovery (Ranney et al., 2024). Service recipients reported that peer specialists cultivated hope and empowerment, reduced distrust of systems, supported need prioritisation and the achievement of life goals beyond healthcare, increased accountability and motivation, and provided emotional support, resources and navigational assistance (Lessard et al., 2024; Ranney et al., 2024). Where negative sentiments were expressed by service users, this related to program delivery, including a focus on a specific tool or model rather than open-ended peer support, and difficulty getting appointments with the peer specialist (Chinman et al., 2021).

The outcomes from a service provider point of view were mixed. In the Canadian community care model (Lessard et al., 2024), clinicians reported that the peer specialist was useful in facilitating communication and patient attendance, providing support with psychosocial needs and overcoming therapeutic impasses (where the GP was struggling to resolve social needs or recurrent complaints that could not be medically resolved). Mayer et al. (2016) also found that clinic staff found peer workers useful for helping providers to understand community level influences on health and provide more culturally appropriate care. Through developing unique connections, peer workers were seen as able to help address barriers to patients engaging in healthy behaviours and promoted adherence to treatment plans and specialist referrals.

## Best practice (barriers and enablers to integration & supporting peer fidelity)

**Objective 2:**

Identify best practice regarding the embedding of peer support in primary care settings, including the barriers and enablers to integration and with consideration for peer support fidelity

Despite the positive outcomes documented above, there was significant misunderstanding, mistrust, and fear around peer specialists providing support which presented as a major barrier across studies. Siantz et al (2016) suggested that in some multidisciplinary teams, it may be unclear what the peer specialists provided, and therefore peer providers were seen as an unnecessary addition to the team. Whilst this article reviewed a program from 2013, when there was less understanding of what peer workers do, similar confusion about the peer worker role was reflected in later studies (Lessard et al., 2024; Shepardson et al., 2019; Shook et al., 2024). Stigma and discrimination towards peer specialists were also documented from some individuals seeking support.

Additional barriers to integration within primary care settings included:

- lack of resources: clinic space and concerns about financial sustainability, inadequate administrative support, lack of user-friendly resources customised to local needs, problems hiring and maintaining suitably experienced workers and supervisors
- poor program functions or planning: lack of clear parameters for how peer services would function, lack of clearly defined workflow/referral and communication models

Overall, these barriers appear to contribute to low referral or uptake rates for peer services and limit the peer role.

Regarding enablers to integration within primary care settings, the following themes were identified across the articles reviewed:

- External pre-implementation and implementation support provided by someone with solid knowledge of lived experience (peer) work
- Physical presence of peer specialists in primary care setting and highly visible: co-location or close by, attendance at team meetings, open to warm handoffs, able to participate in spontaneous meetings
- Clear program guidelines including clear workflows, structure for referrals, feedback loops to primary care provider, clear role differentiations
- Training and education for both primary care staff (education regarding what peers do/don't do) and peer specialists (supervision, community of practices)
- Senior level champions
- Ongoing marketing of peer services to both patients and primary care providers: presentation at team meetings, referral handouts/brochures, posters in waiting room
- Relationship building, educating and building trust with primary care providers
- Tailoring of program to local context and needs, flexible programs and staffing
- Government policy and financial backing
- Administrative support: office/private space within primary care setting, scheduling support, technology to coordinate care

## Potential models

**Objective 3:**

## Explore potential models that demonstrate effective, compassionate approaches to mental health care that go beyond traditional medical treatments

The following programs or models outlined below were described and/or evaluated within the articles reviewed. Details from the grey literature have also been incorporated into this section to provide further detail on each program.

A common theme across the reviewed articles was the importance of adapting models or programs to meet local needs and contexts, rather than following a specific, structured program or model. Program characteristics deemed important included the peer specialist having time to spend with the person to build a relationship (Lessard et al., 2024), and individuals able to get an appointment with the peer specialist easily, and preferably on the same day (Chinman et al., 2021; Shook et al., 2024). Whilst Ranney et al (2024) suggests the importance of peer specialists being matched on a variety of factors and lived experiences, Lessard et al. (2024) argue that a peer specialist can connect through sharing hardships and overcoming them, levering knowledge and connections rather than needing a similar health/social condition. However, this study does caution this involved a highly experienced peer worker. In other situations, being more closely matched on factors other than lived experience of mental health challenges may be an important factor for building rapport and trust quickly, particularly given the public stigma associated with mental health challenges (Siantz et al., 2016).

### PS-PC intervention (Australia)

The peer support-primary care (PS-PC) intervention is a pilot program set up specifically to evaluate the potential of lived experience (peer) support for people seeking metal health consumers within primary care settings in Australia. The intervention seeks to improve patient access to supports, improve self-efficacy in navigating mental health care, increase self-management, mitigate physiological distress, and promote personal recovery. The program is being evaluated for enhancing self-efficacy of those accessing mental health supports, assessing the feasibility of peer support in GP settings and identifying barriers to implementation. It is being funded by a Consumer led National Medical Research future fund grant over three years.

Commencing in 2024-25, the program has been delivered in four general practices, three regional and one remote across Queensland, Tasmania, and South Australia, and is in the final stages of evaluation.

The intervention was designed using an Experience Based co-designed framework (EBCD) which combines knowledge and experiences of those who provide and receive mental health care. This included a stakeholder reference group, semi structured interviews with Australian mental health consumers, families, and peer workers, GPs, practice managers, nurses and reception staff, and workshops with practice staff, MH consumers, sector specialists, peer workers and community organisation representatives.

As the program implementation or evaluation is yet to be published, the program description is based here on intended implementation, as documented in the reviewed article by Lawn et al. (2024). However, from consultation with the research team, it is understood that some of these aspects changed over the course of implementation. For example, according to the original design as documented in the reviewed article, peer support workers were intended to be co-located within primary care, with the clinics providing quiet consult rooms and technology. However, from consultations with the research team, it is understood that peer workers were instead located within employing community service organisations, through which GPs referred out to.

GPs or practice nurses were to use prospective enrolment to compile a list of people living with mental health conditions currently attending the practice who may benefit from the PS-PC intervention. The program was also promoted within waiting rooms. GPs were to screen participants for eligibility in the study, introduce the idea of peer support and provide some key details for referral. A peer coordinator then matches individuals with an appropriate peer worker. Together the individual and peer worker plan for support together. Support may entail emotional and practical assistance, phone calls, home visits, community linkage, and sharing of strategies to enhance lifestyle behaviour (e.g., social connection, physical activity, stress management) to build self-efficacy and self-care and to set recovery goals. 12 hours of practical and emotional support was allocated over 3-4 month period, with the option to extend. Face to face consultation were to be preferenced however tele-health was available in rural settings where face to face unavailable.

As far as can be known, this trial is the first of its kind in Australia. Given its similarities with the First Step Support program being considered by CoMHWA, the findings and learnings from the intervention will provide valuable information. From initial discussions between the author and the researchers involved, several barriers to effective implementation were noted. These included difficulties securing, training, supporting and sustaining peer workers, particularly in rural areas, hierarchy between peer workers and GPs, community stigma, and difficulties getting GPs to refer into the program in some settings. Enablers appear to be strong, cohesive practices where communication between health professionals is prioritised, strong communication strategies between GPs and peer programs, including feedback to GPs and support so that GPs can explain peer work quickly and easily to individuals during consultations. Such enablers and barriers reflect findings from the scoping review.

## Caring community model (Canada)

Caring Community is a participatory research program examining the integration of peers into primary care teams to provide social support, coaching, and community connection, thereby connecting primary health care in with the broader community and tackling social determinants of health. The program, implemented in 2016, claims a collaborative approach which recognizes the knowledge of all: peers, researchers, clinicians, community groups, citizens, and system leaders. Unlike other peer programs, Caring community adopts an 'integrated care orientation', supporting people with complex health and social needs rather than being disease or population-specific.

Lessard et al (2024) is the only peer-reviewed literature within the review that reported on this model. However, there also exist several pieces of grey literature, including the project website and an opinion piece published in the British Medical Journal.

The model involves the following:

GP identifies patients who would benefit from peer support (not matched on similar health issues but rather low engagement, low adherence to treatment, social challenges, limit to GP solutions)

GP facilitates joint face to face introduction to launch relationship, summarise reason for referral and to demonstrate the partnership between the GP and peer worker

Follow up meetings between peer worker and patient are arranged at clinic, hospital, community, home or phone. Together, they work together on goals, identify what resources they have in themselves or community (examples: feeling confident to express needs to specialist, wanting to socialise more), and forging connections. Peer worker focuses on listening without trying to find a solution, coaching and connecting.

The peer worker is co-located in the GP clinic. The peer worker has no access to medical files, and clinical staff have no access to what patients share with the peer worker, except for an emergency or where informed consent is provided. The peer worker role focuses on recognising patients as people with agency, strengths, and capacities, accompanying people towards their life goals, fostering relationships with community resources and supporting mutual support within communities. Rather than just focus on the individual, in the caring community model, the peer worker aims for cross-sectoral collaboration between a primary care clinic, community organisations, citizens, and civic institutions. The peer worker also attends primary care multidisciplinary team meetings, thus contributing to the education and training of other primary care workers.

The evaluation conducted by Lessard et al. (2024) suggests that the program cultivates hope and empowerment, reduces distrust of institutions, helped individuals to prioritise needs, navigate system and achieve life goals beyond health care. GPs find it useful for overcoming therapeutic impasses, facilitating attendance and communication with the patient, and providing support for psychosocial needs. However, as documented elsewhere, significant work is required to build understanding, acceptance and trust of the peer role, which can otherwise serve as a significant barrier.

The following quote, from a Canadian GP, provides insight into the potential benefit of a peer worker from a GP perspective (Boivin & Rouly, 2020):

> *As a physician working in a primary care group practice of 12 000 patients, in a disadvantaged neighbourhood of Montreal (Canada), I have often had the feeling of being the "right answer to the wrong problem." Many of my patients present with medical symptoms (depression, chronic pain, fatigue and anxiety) that are exacerbated by underlying social problems (isolation, poverty, divorce, bereavement, stress, violence or work difficulties). I can sometimes refer those patients to a social worker or psychotherapist, but for many, this is met with suspicion ("You mean it's in my head?"), resistance ("I've seen a shrink before and it didn't help") or practical barriers ("I don't have the money"). Most of all, I feel that health professionals are a poor substitute for a caring friend, family member, or neighbour. It was keen awareness of these issues that prompted me to approach Ghislaine, a much trusted and valued patient partner at our University of Montreal partnership programme, to adopt a new way of caring for patients together. Her extensive knowledge as a patient and caregiver, her ability to listen without judgement, her humility and her diplomatic skills gave me confidence that working together we could deliver what I could not do alone.*

It appears there is only one peer worker employed within the model, who had a very high level of experience. The model does not appear to have been expanded into other primary care clinics within Canada. Findings and recommendations from the program must thus be adopted cautiously, despite the model seeming to align pragmatically with the 'First Step Support' proposal.

## Veteran Affairs model (USA)

The VA model of peer specialists supporting mental health within primary care teams was the most researched and published model within the reviewed literature. The VA program, intended to address broad challenges to access and engagement and shift towards patient-centred, strengths based approaches to mental health, has incorporated peers for over two decades and is the largest single employer of peer specialists (Shepardson et al., 2019). Over 1400 individuals are employed as peer specialists, with roles ranging from apprenticeships through to leadership roles (Shook et al., 2024). Originally employed within mental health settings (what is referred to in the US as behavioural health settings), in 2014, VA, started employing peer specialists in more generalised primary care settings via the Peers in PACT program (Patient Aligned Care team), however this has not been widely deployed, with integration studies still being undertaken (Ranney et al., 2024; Shepardson et al., 2019; Shook et al., 2024). PACTs use multidisciplinary team approaches, with an underpinning principle of patient knowledge, skills and motivation as vital, which make them particularly suited to employing peers. Within VA settings, peer specialists typically facilitate groups, provide individualised support, resources and system navigation (Ranney et al., 2024).

Whilst findings from evaluations of VA models are broadly helpful in informing a potential program in WA, the context in which VA peer support is delivered (existing within large, multidisciplinary teams, and working with veterans) means that they may only be some-what applicable to the First Step pilot.

## Integrated care/Collaborative care models

Integrated care models, sometimes referred to in the literature as collaborative care, involve multi-disciplinary teams working together in primary care. Collaborative care models typically consist of multiple professionals working together using structured management plans, pharmalogical and non-pharmalogical supports, scheduled follow-ups with patients and enhanced interpersonal communication. Integrated care involves the same but with professionals employed under the one organisational framework (Isaacs & Mitchell, 2024). Such models are intended to be consumer-driven and co-designed, ensuring the consumer is considered as a whole, including their culture, family, and community, and committed to identifying and overcoming barriers to access (McSherry et al., 2025; WA Primary Health Alliance, 2016).

Evaluations show that integrated care in primary health settings are particularly suitable for improving mental health outcomes (Isaacs & Mitchell, 2024; McSherry et al., 2025). Integrated primary care mental health services enable earlier and easier access to mental health support particularly for those who need additional support beyond what a GP can provide but may not meet the criteria for secondary mental health services, or may be hesitant to access such services (McSherry et al., 2025).

Typically, mental health integrated care involves a co-located mental health worker who works closely with the GP and the rest of the primary care team. On the lower end of the spectrum, support provided by allied health professionals is largely independent of the GP, whereas in more integrated models, all workers actively partner together to meet the total health care needs of patients. Such environments would appear to provide an ideal environment in which to introduce peer workers, given the culture and resources are already in-place for multidisciplinary teamwork. However, as found by Siantz et al. (2016), this can also present a limitation where the value and scope of peer work is not clearly defined from that of other allied health professionals.

There were two articles include in the scoping review where peer workers were part of integrated models; Mayer et al (2016) and Siantz et al (2016). In addition, Ratzcliff (2017) consulted with peer workers to develop a resource for achieving integrated care within primary mental health care settings. In both service models, the peer workers provided a navigation role, but as opposed to social prescribing (reviewed below), this pertained to only navigating health care systems rather than linking individuals in with the broader community. Not included in this scoping review, Schewizer (2021) reviewed the peer navigation literature related to mental health for the NSW Mental Health Commission, finding the literature on peer navigators within primary care extremely limited, suggesting that the use of peer workers in integrated settings remains limited, despite their potential value (Swarbrick, 2013). Peer workers within the two reviewed studies also provided education, supported individuals to clarify needs or priorities prior to the GP consultations, checked in with people between appointments and supported specialist referrals (Mayer et al. 2016). Importantly, Mayer et al. (2016) also reports on the education that peer specialists can provide to other primary care providers in understanding community level influences on health and enable more culturally appropriate care.

A more general review of the literature on mental health integrated care undertaken by the author also highlighted an integrated model rolled out across 31 primary care networks in the UK, in which lived experience practitioners were sometimes involved as part of a broader mental health team, supervised by a clinical psychologist and clinical lead (McSherry et al., 2025). However, this review did not speak specifically to the role the lived experience practitioners played, or their influence on outcomes.

Whilst not included within the scoping review, but nevertheless providing relevance to an Australian setting, Isaacs and Mitchell (2024) reviewed the evidence on models of mental health integrated care within primary health settings that may be transferable to Australian settings. In Australia, GPs have traditionally worked in smaller, private practices, providing comprehensive and continuing care. However, increasingly clinics are becoming larger and more corporatized, which has implications for continuity of care, but also potentially provides opportunity for more integrated care. Key elements of effective mental health integrated care models in primary care include co-location (with no distinction in terms of signage/clinic names), trained mental health workers, a ‘case management’ approach which requires team work and good communication and regular follow ups (Isaacs & Mitchell, 2024). Factors that contribute to effective implementation include general practices being willing to accept and promote system change, presence of care manager on site, adequate training and supervision for staff, standardised workflow and pathways, clear role boundaries, consolidated records, and regular communication between staff.

Such elements and implementation factors reflect the elements and implementation factors found in the scoping review presented in this report, regarding peer work in primary care settings, suggesting such factors are important for integrated care to work regardless of the discipline being integrated. Isaacs and Mitchell (2024) suggest that integrating primary care could work better in Australia within larger practices where a business case for this model would prevail, with primary health networks best placed to lead this change. Interestingly, this conflicts with what was anecdotally shared from the findings of the PS-PC intervention, whereby it was thought that peer workers are best integrated into smaller clinics where it is easier to build a close relationship and maintain regular communication with GPs. Larger corporate practices, where people may see different GPs each visit, also make it harder to develop the trusting relationships that were identified as an important factor in implementing peer work into primary healthcare settings (General Practice NSW, 2013).

Integrated care models have been piloted and evaluated in Australia for the purposes of improving the physical health of people using secondary mental health services, with some involving peer workers (Maylea et al., 2022). The ICC pilot, evaluated by Maylea et al. (2022) was found to hold significant potential, being highly valued by consumers despite implementation challenges. The pilot program lacked a clear model for peer work, struggled with staffing issues and a lack of understanding of peer work from stakeholders. While peer work was appreciated when consumers were aware of it, consumers were often unaware of the peer worker or what they did.

## Social prescribing

Social prescribing was not mentioned in any of the journal articles reviewed. However as this was an area of interest to CoMHWA outlined in the research objectives, a non-systematic narrative review of social prescribing is included here.

Social prescribing can be understood as a mechanism for identifying, and linking individuals with, non-clinical sources of support within the community, for the purposes of improving wellbeing. Such supports may include book clubs, walking clubs, men's sheds, coffee mornings, gym classes, befriending groups and so forth. Most commonly, social prescriptions involve referrals for exercise or other physical activities or art or craft related activities (Zurynski et al., 2020). Whilst social prescribing can happen in various ways, the most common models involve a GP either directly referring to a community resource or program, or alternatively, referring someone to a 'link worker', sometimes also referred to as a 'navigator' who will discuss with the individual their interests and needs, and then link them to relevant community supports. Link worker roles can vary from referring and sign-posting, through to a more holistic and instrumental approach with formal engagement, setting of health goals, and practical and emotional support (Baker et al., 2024; Calderón-Larrañaga et al., 2022; Zurynski et al., 2020). Social prescribing is a way to leverage community assets to meet otherwise unmet health and social needs (Baker et al., 2024).

Social prescribing is thought to be particularly suitable for individuals experiencing mental health issues due to an over-medicalisation of experiences, isolation due to discrimination, and loss of identify after diagnosis, and the phyco-social nature of distress (Aggar et al., 2021; Cooper et al., 2022; Royal Australian College of General Practitioners & Consumers Health Forum of Australia, 2020; Sharman et al., 2022) Social prescribing has the potential to meet social needs left unaddressed through GP prescriptions for medication or referrals for secondary mental health services. Exercise related social prescribing activities, in particular, are recommended for individuals experiencing mild to moderate depression, prior to prescribing medication (Griffiths et al., 2022). Other groups commonly identified as potentially benefiting from SP include those experiencing social isolation, those with long-term conditions (with or without mental health concerns) or with co-morbidities, and older adults (Zurynski et al., 2020).

In formal settings, social prescribing, like lived experience (peer) work, is a relatively new area of study, and thus the way in which it is enacted is highly variable, with evidence for its effectiveness still being documented across various settings and contexts. Arguably, many health professionals, including GPs, community workers, social workers and peer workers have always been practicing social prescribing, but not called it as such, or not done so within a formal program. Panaite (2024), for example, delineate five types of objectives in peer support: navigation, alongside relationship building, emotional support, promotion and advocacy. The naming of such practices as 'social prescription' has come about to align such practices more closely with medical health care settings.

Most evaluation studies on social prescribing originate in the UK, which is leading the way with formalising national social prescribing pathways and policy support. Whilst Australia does not have a national model on social prescribing, there is increasing support for social prescribing from both GPs and consumer advocates (Baker et al., 2024; Royal Australian College of General Practitioners & Consumers Health Forum of Australia, 2020; Sharman et al., 2022; Zurynski et al., 2020). The first documented social prescribing pilot program for individuals with a diagnosis of mental illness was implemented in 2016/17, evaluated by Aggar et al. (2021). This small study found that the program improved physical and psychological quality of life and health satisfaction, and suggested that social prescribing fits well within Australian health policy and within primary health network funding models.

Social prescribing is also outlined in the Australian Department of Health 10 year Primary Health Care Plan (2022), requiring support for 'PHNS to develop, refine and scale evidence-based models of social prescribing and system navigation supports for at-risk and disadvantaged groups' (p. 37). Several pilot programs are currently being undertaken and/or evaluated in Australia (Jayasinghe et al., 2023; Ridge et al., 2024; Thomas et al., 2020). In QLD, the Gold Coast Primary Health Network funds Plus Social, a social prescribing program run by PCCS to support individuals significantly impacted by mental ill-health, and in NSW, Social Rx is delivered under funding from Central and Eastern Sydney PHN. The Australian Social Prescribing Institute of Research and Education brings together research and education on social prescribing in Australia.

Zurynski (2020)'s rapid literature review of the social prescribing literature is a few years old but useful in that it synthesised evidence to 2020 on the effectiveness of social prescribing programs specifically to inform primary care policy in Australia. It found most studies on social prescribing produce mixed/inconsistent results regarding the impact on patients, GPs, link workers, and on the health system. Similar findings have been reported in multiple systematic reviews since, with most reporting limited evidence for the effectiveness of social prescribing due to methodological limitations (Cooper et al., 2022; Griffiths et al., 2022; Kiely et al., 2022; O'Sullivan et al., 2024). Cooper et al. (2022) for example, found that whilst 16 out of 17 studies reported statistically significant improvements in outcomes (mental health, mental well-being, general health, or quality of life), robust conclusions on the effectiveness of social prescribing for mental health-related outcomes cannot be made due to methodological limitations in the existing research. However, paralleling in some ways the research on peer work, Zurynski (2020) surmise this may be because quantitative measures that focus on health-related outcomes may not adequately capture complex concepts, such as community connectedness, social engagement, confidence, and self-determination. Health and wellbeing improvements may also occur over a long period of time and are not being captured due to a lack of long-term studies (Cooper et al., 2022; Griffiths et al., 2022). Further, social prescribing is based on community resources identified locally, and thus if community resources (social, cultural, green space connections) are unavailable or limited, this can affect outcomes (Calderón-Larrañaga et al., 2021; Griffiths et al., 2022).

Qualitative studies, which are often deemed methodologically 'weaker', predominantly report positive outcomes from patients (Cooper et al., 2022; Griffiths et al., 2022; Zurynski et al., 2020). Individuals generally report improvement in wellbeing, quality of life, self-management, physical activity level and social connectedness. However, studies also generally show that a high portion of individuals referred to social prescribing do not engage, and drop-out rates are generally high. Further investigation is needed in this regard (Cooper et al., 2022). The perceptions of GPs and other health professional are mixed (Zurynski et al., 2020). Again, paralleling the findings from the scoping review within this report on peer specialists in primary care settings, GPs who understand the purpose of social prescribing and have developed relationships with link workers/navigators have higher levels of satisfaction with social prescribing (Calderón-Larrañaga et al., 2021; Zurynski et al., 2020).

Enablers of implementing social prescribing programs effectively include:

- a phased rollout with clear and appropriate organisation, infrastructure, and management
- strong stakeholder engagement from all relevant sectors
- strong buy in from GPs and belief in social prescribing (a 'predisposed practice culture')
- good communication
- a clear understanding of shared goals
- training for GPs and link workers

Identified barriers include:

- a lack of coordination and collaboration among stakeholders
- limited understanding of social prescribing amongst GPs
- limited engagement with frontline health professionals including GPs
- GP workload and time pressures, making it difficult to bring non-clinical approaches into conversation

Important factors for program success include:

- sustainable funding and bottom-up poicy making approaches
- initial contact with link worker easy for GP (eg. IT integration, lack of red tape, single point of contact and/or co-location)
- regular positive feedback to GPs (strong feedback loop) and the provision of robust evidence on social prescribing to GPs
- trust between the GP and patient, GP and link worker, and link worker and patient/service user, developed through sustained, unhurried and non-judgemental relationships
- Relational rather than transactional models, that enable ongoing and open ended, flexible interactions personalised to needs, rather than a structured model of assessment and referral with pre-established limits
- Emotional and practical support alongside service navigation, particularly peer support
- Regular follow up by link workers and/or attendance at planned activities
- Ongoing supervision and training for link workers and GPs
- GP and link workers experience and knowledge of individuals circumstances, social prescribing and community resources
- Appropriate staffing to ensure capacity for innovative community engagement initiatives rather than a "fire fighting" approach (meeting immediate and urgent demands).

A model involving link workers rather than direct referral from GPs is often preferenced for several reasons (Baker et al., 2024). Link workers have a higher level of knowledge and connections to local supports than GPs, and can dedicate additional time to spend with individuals seeking support. Link workers also can follow up non-medical challenges without the same cost as a GP (Baker et al., 2024). However, a holistic model, whereby GPs understand, consider and integrate individuals needs in collaboration with a link worker, rather than simply referring on to a link worker, is considered best practice (Calderón-Larrañaga et al., 2021).

These barriers and enablers to integration of social prescribing, alongside the characteristics of 'good' social prescribing programs reflect closely those identified in the scoping review of peer work within primary health care settings. Whilst social prescribing is often linked to integrative care, its connections with lived experience (peer) work, are less discussed within the existing literature, despite social prescribing aligning closely with lived experience (peer) work values and approaches of person-centred, holistic, and relational support.

On a final note, there are some critiques of social prescribing worth noting, given they have important implications for implementation and practice, particularly when being integrated with lived experience (peer) work (Calderón-Larrañaga et al., 2021). It is important to avoid social prescribing becoming an individual and neoliberalised solution (such as a focus on self-care, patient activation and resilience) to what are social inequalities and structural injustices. Such approaches place the responsibility (and blame) on the individual to 'overcome' significant barriers to community connection, overshadowing the context of possibilities and constrains in which these actions may (or may not) happen. Social prescribing undertaken by lived experience (peer) workers must draw on a dynamic open-ended relationship between care networks, with a focus on breaking down barriers, rather than time bound, motivational type coaching or straight forward referral pathways. Social prescribing practices should also contribute to enhancing GP and other healthcare workers understandings of consumers wider needs and their capacity to respond accordingly (Calderón-Larrañaga et al., 2022).

# Section 4: Discussion and Recommendations

The small number of articles contained in this review reflect the emerging state of peer workers in GP settings and the need for further research in this area.

Given only two of the nine articles focused on outcomes, and most programs evaluated did not reflect an Australian context, it cannot be said with any certainty potential outcomes of the proposed 'First Step' project. However, the research does suggest that peer workers in GP settings have the potential to support both individual health outcomes and support the work of GPs. Peer workers can support individuals to clarify and prioritise their health needs, facilitate communication and attendance, provide psychosocial and navigational support, cultivate hope and empowerment, build community connections, provide education and resources.

Additional supports that peer workers can provide that were not specifically mentioned in the reviewed articles include supported decision making (such as CoMHWA's work with the My Medicines and Me- M3Q tool), support around advanced health care directives and/or crisis planning (Belden et al., 2022) and personal medicine coaching (Deegan, 1997). They can also support GPs and other primary healthcare providers to understand barriers to support, community level influences on health, and provide more culturally appropriate and trauma informed care. It appears peer workers are valued by individuals accessing mental health support within a primary care setting, and also valued by GPs when there is strong communication and understanding of the role. Previous research on peer work in other healthcare settings, and where peer work focuses on physical health care needs also offers support for the potential value of peer workers in GP settings.

Despite the benefits of lived experience (peer) work, many barriers, or challenges to integrating peer workers into existing teams and systems, particularly within clinical spaces, have been documented (Alvarez-Vasquez et al., 2020; Byrne et al., 2016, 2019; Edan et al., 2021; Lawn, Dee-Price, et al., 2024). Persistent discrimination and stigma from other health professionals and the general public exist, alongside a general lack of understanding of the discipline, poorly defined roles and workflows, biomedical dominance and inadequate training and support for both clinicians and peer workers to work collaboratively. Such barriers often result in low uptake of peer work, gatekeeping by health professionals and peer drift, whereby peer work becomes co-opted into more clinical ways of working. The review suggests these are also potential barriers within a primary care setting. Evaluated programs were limited by clinician understandings of what lived experience (peer) workers can provide, a lack of trust and fear. Other challenges include poor workflows and communication, inadequate resourcing, training and support.

An additional challenge within a GP setting, particularly for individuals who are disclosing mental health struggles for the first time, is the stigma associated with mental health, and what it means to meet with a peer worker. To date, peer workers have been predominantly employed in secondary mental health settings, whereby individuals are more likely to identify with having shared lived experience, and thus more likely to engage with a peer worker. The same barrier appears to exist for engaging with link workers in social prescribing programs. Further, the review also identified that a lack of space and resources within GP settings can also present a barrier, particularly given that co-location is an important enabler not only for peer work, but also social prescribing and collaborative care. Lastly, the nature of a primary care setting, as a fast-paced, generalist, and complex medical setting, differs to many other traditional mental health settings in which peer workers are employed. This requires lived experience workers who are experienced, flexible and able to adapt quickly. In addition, the discipline of lived experience (peer) work is much less likely to be known to GPs than health professionals working in secondary mental health settings.

The VA studies in particular, suggest that implementation facilitation is an important factor to success, and these studies provide strong recommendations for overcoming barriers to implementation. Where peer workers have been more successfully integrated into primary care settings, the program has been developed in consultation with local stakeholders and with regard to local needs, practice and community resources, rather than adopting a standardised approach or model. The building of trust in the program with GPs is integral. Strategies such as relationship building, team meetings, education, resources, senior level champions are all recommended. Co-location of peer workers with GPs facilitates awareness, enables ad-hoc communication, enables warm hand-offs, and supports the building of trusting relationships. Clear workflows, supported by technology, shared notes and resources, are required to ensure it is easy for a GP to connect individuals with a peer worker, and receive feedback on progress. The role and expertise of the lived experience (peer) worker must be clearly defined and communicated. Lived experience (peer) workers benefit from ongoing training and discipline specific supervision. Many of the barriers and enablers to integration reflect that of integrated care with other health professionals. However, integrating peer workers has additional barriers related to mental health stigma and discrimination, and a general lack of understanding of the discipline.

The review identified several different approaches where peer workers have been integrated into primary care settings. From an informal review of the literature on integrated care and social prescribing, it appears both practices align well with locating peer workers in primary care settings. These areas are particularly promising given increasing policy support however also require changes to how primary care is funded.

The review did not look specifically at how lived experience (peer) work in primary care settings might address the specific needs of individuals accessing mental health support for the first time who face additional barriers as identified in WAPHA’s need assessments. This would be worthy of further exploration, particularly given several of the reviewed articles suggested that shared experiences across multiple identities and/or experiences are beneficial in building trust and a supportive relationship. The experiences of integrating peer workers in in other primary care settings not specific to mental health, such as women’s health or sexual health clinics (LUMA and M Clinic being examples in WA) may also provide valuable input into a potential pilot program.

The findings of the review suggest that a First Step Support project would align strongly with WAPSN’s aim to enable health professionals to work effectively and deliver comprehensive care, as well as helping individuals stay well in the community and avoid hospital admissions. Table 2 below outlines more specifically how the project aligns with with WAPHA’s mental health guiding principles and priorities as outlined in the Mental Health Strategy 2023-2026.

**Table 2: How First Step Support aligns with The WA Primary Health Alliance Mental Health Strategy 2023-2026**

| **WAPHA's mental health guiding principles** | **How the First step project would align** |
|---|---|
| person centred primary health care that improves consumer experience and outcomes. | The review demonstrated that where lived experience (peer) workers have been successfully integrated into primary health care settings, they are valued by consumers and contribute to positive health outcomes. |
| lived experience engagement across the commissioning cycle. | Enablers to a successful integration project involving lived experience (peer) workers in GP settings involve co-design, development, implementation and delivery by lived experience workers. |
| care that is free from stigma, discrimination or judgement. | Lived experience (peer) workers in GP settings hold potential to reduce stigma, discrimination and judgement through forming relationships with, and providing education to, GPs and other primary health care staff. |
| interventions that are evidence informed, have known effectiveness and are based on individual needs and goals. | The review provides preliminary evidence for the value of integrating lived experience (peer) workers in GP settings, as well as evidence-informed recommendations for successful integration. |
| **WAPHA's mental health priorities** | **How the First step project would align** |
| timely access to primary mental health care for people in under-serviced groups and/or experiencing locational disadvantage. | Review findings suggest that lived experience (peer) workers in primary care settings can be particularly beneficial in reducing barriers to access for individuals seeking mental health support, who may otherwise not engage with secondary mental health services. |
| improve the safety and quality of primary mental health care. | Review findings suggest lived experience (peer) workers in primary care settings can improve the safety and quality of primary mental health care both through individual outcomes and through educating and informing GPs. |
| Enhance efficiency and improve the experience and outcomes of people accessing services, by working with partners to reduce fragmentation between general practices and other services. | Lived experience (peer) workers have the potential to reduce fragmentation between general practices and other services through a social prescribing role. Existing models of peer navigators exist in other states. |

## Recommendations

Given the review findings, the following is recommended:

1. Appropriate funding should be sought for progressing the First Step Support proposal. Given that integrating lived experience (peer) workers into GP settings aligns closely with WAPHA's current mental health strategy and with primary health network policies more broadly, WAPHA would be an ideal funding partner.

2. As outlined in CoMHWA’s First Step Support project brief, and building on the findings from this review, further input into the development of a potential pilot should be gathered from consultations with GPs and consumers at a local level, to ensure the development of a pilot program is contextualised to a WA setting. Also recommended is further input from lived experience (peer) workers involved in social prescribing initiatives in NSW and QLD, as well as lived experience (peer) workers co-located in other primary care settings. Such consultation should not replace pre-implementation and implementation facilitation when integrating lived experience (peer) workers into specific GP clinics.

3. Given the PS-PC intervention most closely resembles the First Step Support project proposal, learnings from this intervention, whether through publication or further documented meetings with the evaluators, should inform future steps.

4. Given the innovative and emerging nature of integrating peer workers into primary care settings, CoMHWA should consider partnering early with an appropriate research team to evaluate the pilot and publish findings for a broader audience, as well as to support future scaling up.

5. Social prescribing has the potential to align well with lived experience (peer) work within a primary care setting, and should be considered as one aspect, among many, of a peer worker role within GP settings. Careful consideration needs to given to ensuring social prescription does not compromise lived experience (peer) values.

6. Further consideration, taking into account local context and demand,  should be given to whether a pilot should include, prioritise, or exclude individuals who are not seeking mental health supports for the first time.

Table 3 below outlines specific recommendations regarding the logistical and operational aspects of integrating peer workers into GP clinics.

**Table 3: Logistical and operational recommendations**

**Planning/pre-implementation**

1. Use of external facilitation in the planning/pre-implementation stage to:

   - assess and respond to service user needs, organisational factors, and contextual requirements,
   - develop implementation and evaluation plans in consultation with all stakeholders,
   - foster relationships between stakeholders, with an emphasis on building trust with clinicians,
   - develop educational resources, and
   - provide training, ongoing monitoring and support.

2. External facilitation should be provided by someone with expert knowledge of lived experience (peer) work approaches, values, and practices.

3. Peer specialists and primary care staff should be involved in all stages of program development (pre-implementation and implementation) and ongoing continuous improvement.

4. Planning needs to be highly contextualised to the practice and patient needs, capacity, and resources.

5. Consider use of GROW worksheet and associated tools to support pre-implementation as documented in Ratzcliffe et al. (2017)

6. Consideration should be given to piloting programs initially in metro areas due to barriers around staffing and confidentiality in more rural/regional areas.

7. A GP setting that already has well established communication strategies between staff and an interest in social prescribing or integrated care should be prioritised for piloting.

8. Strategies for overcoming stigma in engaging with a lived experience (peer) worker for the first time should be developed. This will involve significant buy-in from the GP, given the review suggests that the relationship and trust between service user and GP is what facilitates engagement.

**Implementation Support**

1. External facilitation or leadership within the implementation phase is recommended to build strong relationships and trust in the program, adapt workflows and resources where required, and provide training and supervision.

**Workflow, guidelines, and resources**

1. Clear referral pathways, workflows and resources should be developed during pre-implementation to support clinicians and peer specialists (eg. when to refer, when to provide feedback).
2. Clear communication and feedback loops between peer specialists and clinicians need to be established (eg. shared notes, letter responses to referrals, team meetings)
3. A clear scope of work must be developed and communicated to distinguish peer specialist role from that of other providers.
4. Educational resources for both clinical staff and patients should be specifically designed for peer work in primary practice rather than generalised peer support in secondary mental health settings.
5. Any guidelines developed should allow flexibility for individual sites to tailor their peer support programs to suit local needs

**Support characteristics**

1. Co-location is strongly recommended where resources allow.
2. Same day access and/or warm hand-offs should be facilitated where possible.
3. Peer specialists should be easily accessible to clinicians via phone, email, or in-person and highly visible within the primary care setting.
4. Peer services and approach should be flexible and individualised rather than following a specific program.
5. Where possible, peer specialists should be matched based on a variety of factors.
6. Temporality an important enabler: peer specialist needs time to listen, gain trust, build relationship, understand needs, and make connections.
7. Face to face support may be preferred, with flexibility for other options. However, this will depend on local context.
8. Peer specialists must demonstrate flexibility, confidence, resourcefulness, and ability to communicate and network well. Consideration needs to be given to the skills needed to adapt to a GP setting.
9. Ensure adequate logistical support will be available for peer workers including access to private meeting spaces in primary care, a dedicated phone line, a computer, and appropriate shared record keeping.

**Stakeholder buy-in**

1. A GP champion should be identified and utilised.
2. Frequent reminders and marketing materials for patients and primary care staff about availability, when to refer, what peer support is, are important for facilitating referrals.
3. Where possible, peer specialists should shadow GPs initially and engage with patients in session to allow GP’s to witness peer approach.
4. A specific group or clinical pathway that peer specialists could assist with should be identified to quickly demonstrate the value of peer work and build trust in the potential for peer work.
5. Testimonials from individuals who benefitted from peer services, as well as local program evaluation data should be shared regularly.
6. Regular communication between peer specialists and the primary care team should be prioritised, including staff meetings, team meetings, verbal feedback, co-signed progress notes.

**Training & Education**

1. Peer specialists must be provided with initial training, continuing education, and opportunities for peer networking and professional development, including a community of practice
2. Given the lack of understanding and trust expected initially, an experienced and adaptable lived experience (peer) worker is recommended
3. Primary care staff should be made aware of peer training and ongoing supervision
4. Primary care staff require training and education on the discipline of lived experience (peer) work and scope of practice

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# Appendix – A1

| **Article** | **Lessard et al. (2024). Can you be a peer if you don't share the same health or social conditions? A qualitative study on peer integration in a primary care setting. *BMC Primary Care*. 25: 298. https://doi.org/10.1186/s12875-024-02548-5** |
|---|---|
| Objective | Examined the feasibility, acceptability, and perceived effects of a peer support worker in primary care setting |
| Methodology | Participatory qualitative study 2020-2022, patients, carers and clinicians interviewed, thematic analysis |
| Model | Caring community model |
| Location | Canada |
| Limitations | Only one peer support worker involved with the program, small study |

| Program details | Outcomes | Barriers/Enablers | Implications |
|---|---|---|---|
| Peer worker co-located in GP clinic, provides social support, coaching, and linking with resources in community<br>GP predominantly referred people with high social needs or recurrent complaints that could not be medically resolved | **Provider reported benefits:**<br>• overcoming therapeutic impasses<br>• facilitating communication & attendance<br>• providing support with psychosocial needs<br>**Recipients:**<br>• cultivated hope and empowerment<br>• supported achievement of life goals beyond health care<br>• reduced distrust of institutions<br>• helped to prioritise needs and navigate systems<br>Study argues peers connect through sharing hardships and overcoming them, leveraging knowledge, strengths and connections, rather | **Enablers:**<br>• Temporality one of most important enablers: peer worker needs time to listen, gain trust, build relationship, understand needs and make connections<br>• Experience: caution they had a highly experienced peer worker<br>**Challenges:**<br>• peer role limited by clinicians understanding of the nature of the support offered and peer role acceptance<br>• work needed to educate and build trust in providers: fears of harming patients, fear of unknown, fear of exhausting peer | • model has merit<br>• requires clinician training and education to improve acceptance and role understanding, to build trust<br>• requires well trained and experienced peer worker<br>• peer worker must have time as a resource to draw upon |

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| | than needing similar health/social conditions. | | |

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|---|---|
| **Article** | **Lawn et al. (2024). Evaluation of lived experience Peer Support intervention for mental health service consumers in Primary Care (PS-PC): study protocol for a stepped-wedge cluster randomised control trial. BMC Trials. 25: 319. https://doi.org/10.1186/s13063-024-08165-y** |
| Objective | This article describes the PS-PC intervention (a lived experience peer support intervention for mental health service consumers in primary care) and the proposed evaluation protocol. The evaluation seeks to:<br>Understand the efficacy of the PS-PC in enhancing the self-efficacy of those accessing MH support at a primary care level<br>Assess the feasibility of peer support in a GP setting and identify barriers to implementation |
| Methodology | Stepped wedge cluster RCT, mixed methods.<br>264 patients (Scale based questionnaire over four time points measuring mental health and other health outcomes)<br>150 carers and 16 peer workers pre and post, 20 medical practice staff members (attitudes towards peer workers) post.<br>60 interviews and six focus groups with all |
| Model | PS-PC |
| Location | Australia (QLD, TAS, SA): 3 regional practices, 1 remote |
| Limitations | Only describes methodology, findings yet to be published. |

| Program details | Outcomes, Barriers/Enablers | Implications |
|---|---|---|
| Design of process<br>Intervention designed using a Experience Based co-designed framework (EBCD) – combines knowledge and experiences of those who provide and receive mental health care:<br>• Stakeholder reference group<br>• Semi structured interviews: Australian mh consumers, families, and peer workers<br>• Workshops with practice staff, MH consumers, sector specialists, peer workers and CMO reps.<br>• Semi structured interviews with GPs, practice managers, nurses and reception staff: experiences of staff and how peer workers might be accommodated | N/A | • Provides a good example of design and evaluation process to model future pilot programs on<br>• Findings from this project will provide vital information for a WA based program |

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| Recruitment and enrolment (for intervention & evaluation)<br>• GPs use prospective enrolment to compile a list of people living with mental health conditions currently attending the practice who may benefit from the PS-PC intervention.<br>• GPs introduce and provide key details.<br>• Also promoted within the waiting rooms.<br>• GPs screen participants for eligibility<br>• Practice nurse to complete informed consent<br>Intervention<br>• Peer coordinator matches individuals with peer worker<br>• Individual and psw make plan together<br>• Support may entail emotional and practical assistance, phone calls, home visits, community linkage, and sharing of strategies to enhance lifestyle behaviour (e.g., social connection, physical activity, stress management) to build self-efficacy and self-care and to set recovery goals.<br>• 12 hours of practical and emotional support provided by peer workers over 3-4 month period, option to extend<br>• Face to face consultation preferenced however tele-health will be used in rural settings where face to face unavailable<br>• Clinics provide quiet consult rooms & tech (NB: changes to model made since publication, see report findings) |  |  |

| **Article** | **Chinman, M., Goldberg, R., Daniels, K. *et al.* Implementation of peer specialist services in VA primary care: a cluster randomized trial on the impact of external facilitation. *Implementation Science* 16, 60 (2021). https://doi.org/10.1186/s13012-021-01130-2** |
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| Objective | to evaluate the impact of external facilitation on overcoming challenges commonly associated with implementing peer specialist services in new settings |
| Methodology | cluster-randomized hybrid II effectiveness-implementation trial: minimal implementation support vs. facilitated implementation on the deployment of veteran peer specialists in 25 VA primary care settings over 2 years. Conditions were compared on PS workload data and veteran measures of activation, satisfaction, and functioning. Qualitative interviews collected information on perceived usefulness of PS (10 veterans interviewed). |

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| Model | VA |
| Location | USA |
| Limitations | Predominantly looks at effect of external facilitation, but also encapsulates a small qualitative evaluation of PS effects<br>VA setting in US has some differences to the WA primary health context |

| Program details | Outcomes | Barriers/Enablers | Implications |
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| This study evaluated external facilitation on the implementation of VAs within PACTS. External facilitation is an evidence based implementation strategy, in which outside individuals activate and support implementation by assessing and responding to service users needs, organisational factors and contextual needs. External facilitation was provided for one year at each site by psychologists, tailored to site needs.<br>External facilitation included:<br>• assessment of domains related to local context<br>• connection with key staff via site visits to understand needs<br>• providing overview of PS role and program to primary care staff, deliver training<br>• development of specific implementation and evaluation plans in consultation with PACT<br>• development of educational resources (eg. “What do peers do?”) | • Service recipients described PSs as being “terrific,” “professional,” “easy to talk to,” and “knowledgeable.”<br>• helped in meeting personal goals (e.g., diabetes management and weight loss) with a positive attitude and nonjudgmental accountability.<br>• helped with connection to other services and programs, both within the VA and in the community.<br>• Provided both a sounding board (“he’s the only one that listens to me”) and liaison between Veterans and their PACT teams and other providers (“he knew how to get things done”).<br>• established an immediate comradery: “it’s different if you’ve been there and done that or if you just learned it off a book.” | External facilitation support enabled a higher number of service recipients and supports provided, the commencement of peer support more quickly, and more long-term sustainability compared to sites receiving minimal implementation support. No overall difference in peer support outcomes were noted, although the article notes that the interventions provided by PS (2.3 visits per veteran) may be inadequate to meaningfully impact these outcomes.<br>The article suggests that the facilitators, whilst being trained as psychologists, were very familiar with peer specialist roles and training, and this may be an important requirement for future implementation efforts. | Implementation support is important to overcoming some of the barriers normally experienced in implementing peer support in care settings.<br>The model of support used could be useful for other sites where peer support is being implemented within primary care settings.<br>Implementation support should be provided by someone with solid knowledge of lived experience (peer) work<br>Peer support as open ended and flexible rather than following a specific/structured program should be considered. |

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| • Provision of ongoing monitoring and support<br>This role was separate to PS supervisors. | • Some negative sentiments, predominantly associated program delivery (e.g., the focus on a particular model of Whole Health coaching rather than open-ended peer support, difficulty getting appointments with the PS). | | |

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| **Article** | **Shook, Christina B, Wray, Laura O, Dollar, Katherine M, Matthieu, Monica M, Peeples, Amanda D, Chinman, Matthew, Pomerantz, Andrew S. (2024). Implementation of peer specialists in Veterans Health Administration primary care: Improving program fidelity through enhanced pre-implementation support.** ***Psychological Services*****. https://doi.org/10.1037/ser0000911** |
| Objective | To determine the effects of implementation facilitation of peer support into primary care |
| Methodology | Mixed methods evaluation across two cohorts of 15 sites (one cohort receiving minimal implementation facilitation). Outcome measures included qualitative evaluation of facilitator notes, time to attain implementation milestones, PS productivity and program fidelity. |
| Model | VA |
| Location | USA |
| Limitations | Predominantly looks at effect of external facilitation, VA setting in US has some differences to the WA primary health context |

| Program details | Outcomes | Barriers/Enablers | Implications |
|---|---|---|---|
| Implementation facilitation provided (based on the “Promoting Action on Research Implementation in Health Services Framework”). This involved external facilitation (EF) plus national resources. EF is a bundled set of implementation strategies tailored to the setting and provided within the context of a supportive interpersonal relationship. Provided by facilitation experts with specialised knowledge of implementation and quality | | Implementation facilitation (pre, during, sustainment) resulted in programs achieving fidelity quicker, fostered team cohesion, and provided role clarity<br>**Enablers:**<br>• PS attending team meetings<br>• Psychical presence of PS in PC setting<br>• PS attendance at conferences, community of practice and full package of implementation support | Pre-implementation facilitation important for speeding up implementation of novel practices such as peer support in primary care.<br>Multiple system and contextual factors can enhance or detract from the implementation of PS in PC settings. |

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| improvement approaches. The range of facilitation activities are outlined within the article, from pre-implementation to sustainment, alongside the national resources provided. |  | - Flexibility of programs and individuals (ps who could adept easily to PC settings, and able to provide a range of service options).<br>- Peer support on same day as medical support<br>- Government policy support and funding<br>**Barriers:**<br>- Lack of implementation champions<br>- Lack of PS cohesion with PC team<br>- Supervisors with minimal experience working with PS and limited knowledge of PS competencies and approaches.<br>- Role and function confusion- lack of clearly defined PS role and PC referral flow/standard workflow models – resulting in less referrals from PC providers<br>- Marketing of traditional PS services instead of customised to local needs |  |

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| **Article** | **Shepardson, R. L., Johnson, E. M., Possemato, K., Arigo, D., & Funderburk, J. S. (2019). Perceived barriers and facilitators to implementation of peer support in Veterans Health Administration Primary Care-Mental Health Integration settings. *Psychological Services, 16*(3), 433–444. https://doi.org/10.1037/ser0000242** |
| Objective | Identify perceived barriers and facilitators to implementing peer support in primary care-mental health integration settings |
| Methodology | Semi structured interviews with 25 stakeholders (7 peer support specialists, 6 supervisors, 6 PC-MHI providers and 6 PC providers), conventional content analysis. |
| Program details | VA |
| Location | USA |

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| Limitations | VA setting in US has some differences to the WA primary health context | | |
| Program details | Outcomes | Barriers/Enablers | Implications |
| | | **Enablers:**<br>• administrative support (funding, office/private space within primary care setting, scheduling support, training and resources, networks, supervision)<br>• program functioning (training for staff on what peer support is, clear workflows, structure for referrals, feedback loops back to primary care provider)<br>• team cohesion (reciprocal communication, inclusion in team meetings and program improvement)<br>• Accessibility: PSS easily accessible (presentations at team meetings, referral handouts/brochures, providing feedback on referrals, open to warm hand-offs, location close, highly visible)<br>• Peer characteristics: experiences and knowledgeable, good fit<br>• Role clarity (education on what peer specialists do and don’t do)<br>• clarifying the PSS role based on local PC-MHI need<br>**Barriers:** | |

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| | | • poor program functioning (unfamiliarity with concept and goals of peer support and parameters of program)<br>• inadequate administrative support (unqualified supervision, non-user friendly resources)<br>• role confusion (scope of practice, boundaries between roles)<br>• negative stakeholder attitudes (negative attitudes towards ps from providers, staff and patients, misunderstandings or lack of understandings of peer support)<br>• peer characteristics (skill deficits, perceived as poor fit)<br>• poor team cohesion (mistrust of peer support specialists, lack of respect, not valued) | |

| **Article** | **Siantz, E. Henwood, B. and Gilmer, T. (2016). Implementation of peer providers in integrated mental health and primary care settings. Journal of the Society for Social Work and Research 2016 7:2, 231-246. doi/full/10.1086/686644** |
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| Objective | Examine how peer-based services are implemented in behavioural health care settings in Los Angeles |
| Methodology | Site visits in 2013 across 24 programs: semi structured interviews that evaluated integrated care: staff, clinic observations and chart review, field notes, observation |
| Model | Integrated care |
| Location | USA |
| Limitations | Study focused predominantly within ethnically diverse communities with large homeless populations, providing predominantly outreach support, may differ significantly from WA context, older study |

| Program details | Outcomes | Barriers/Enablers | Implications |
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| Peer providers were primarily | | Stigma of having a mental illness amongst | Whilst there are some |

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| embedded in assertive community treatment teams or community designed programs specifically targeting underserved ethnic populations, those with experience with homelessness, or mental & physical health conditions. Peer provider responsibilities included case management, benefits coordination and treatment planning, outreach. In other settings, facilitated support groups and mentoring. Some trained in Bridge peer health navigation, wellness recovery action planning, or peer advocacy training. | | community meant clients unlikely to engage with a peer provider. Providers also held similar views.<br>In some places, peer providers were deemed not a necessary addition to the existing team which included case managers (elements of peer support deemed to come from others). Peerness was typically defined by some as common cultural or linguistic identity and not lived experience of mental illness.<br>Some places experienced difficulties hiring and maintaining a qualified worker. | significant differences in context, this study did highlight the significant barrier of stigma for both referrals from a primary care provider and uptake of referrals by the service recipient. |

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| **Article** | **Mayer, M. K. , Urlaub, D. M. , Guzman-Corrales, L. M. , Kowitt, S. D. , Shea, C. M. & Fisher, E. B. (2016). "They're Doing Something That Actually No One Else Can Do".** ***Journal of Ambulatory Care Management, 39*** **(1), 76-86. doi: 10.1097/JAC.0000000000000079.** |
| Objective | Identify benefits and challenges to peer support and primary care integration and sustainability |
| Methodology | Semi structured interviews with 18 staff members (managers of peer support workers, clinical staff) across 4 primary care practices |
| Model | Integrated care |
| Location | USA |
| Limitations | Only one of the four practices had a focus on mental health, peer support workers did not contribute to findings |

| Program details | Outcomes | Barriers/Enablers | Implications |
|---|---|---|---|
| Peer support workers were employed to link existing patients to new services, provide education, address patient anxieties before visit, check in with patients between appointments. Peers supervised by a nonclinical manager responsible for behavioural health (mental health) and primary | • Peer supporters more accessible<br>• Form unique connections, helping to address barriers to engaging in healthy behaviours<br>• Help providers understand community level influences on | **Enablers:**<br>• Regular team meetings to facilitate integration of peer support into clinical work flows<br>• External facilitation (consultants or academic institution) helped to develop and understand new staff | Provides a good summary of enablers and barriers to PC implementation |

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| care integration. | health and provide more culturally appropriate care<br>- Promote adherence to treatment plans and specialist referrals | configurations/acceptance of peer support role<br>- Co-location and specific work space for peers<br>- Technology to coordinate care (such as electronic health records)<br>- Frequent communication between peers and clinical staff (spontaneous and regular meetings)<br>- Building confidence in peer support work through making staff aware of peer supervision and training<br>- Making peer supporters visible (eg. adding to EMR note that peer is part of care team)<br>- Building GP support- ensuring they see the value<br>- Senior level champions<br>- Effective messaging re: the unique role of peers<br>**Barriers:**<br>- Sustainability concerns<br>- Lack of clinic capacity to provide adequate space and resources<br>- Unclear definitions and communication around peer scope of work<br>- Lack of staff trust in peer supporters | |

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| **Article** | **Ranney, Rachel M, Goldberg, Richard, Maguen, Shira & Blonigen, Daniel. (2024). Peer specialist-led interventions in primary care at the Veterans Health Administration: An integrative review. *Psychological Services*. https://doi.org/10.1037/ser0000858** |
| Objective | identify and review studies that evaluated interventions led by peer specialists in a VHA primary care setting. |

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| Methodology | Integrative review of existing literature. |
| Model | VHA |
| Location | USA |
| Limitations | Review suggests many articles missing information (eg. whether peers full time or part time, whether primary mental health or general practice, how peers matched). Methodology of review not extensively documented. |

| Program details | Outcomes | Barriers/Enablers | Implications |
|---|---|---|---|
| Review found 13 articles evaluating peer led VHA primary care interventions from 2014 on. | majority of peer-led interventions may lead to benefits for veterans, including:<br>• improvements in overall health/stress/recovery<br>• ability to navigate the VA system<br>• decreases in symptoms, including alcohol use, PTSD symptoms, depressive symptoms, anxiety and global psychiatric symptom severity.<br>Common themes from veteran feedback:<br>• significance/helpfulness of working with a peer with shared lived experiences, which enhanced rapport and trust<br>• importance of personalizing an intervention to individual veteran goals/symptoms<br>• helpful in providing accountability, motivation and | Suggested improvements:<br>• veterans reported a desire for a longer intervention or more time with the peer<br>• importance of matching veterans and peers on a variety of factors and lived experiences, including gender<br>• veterans preferred in-person contact with peers, but other veterans reported appreciating the flexibility and convenience of a phone intervention.<br>PC staff wanted more information about the peers' role and the specific peer-led interventions and greater integration<br>• further role clarification required to ensure peer specialists are not taking on the role of other health care providers | |

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| | encouragement, emotional support, resources, and assistance with navigating the VA and other health care systems. | | |

| **Article** | **Ratzliff, A., Phillips, K. E., Sugarman, J. R., Unützer, J., & Wagner, E. H. (2017). Practical Approaches for Achieving Integrated Behavioral Health Care in Primary Care Settings. *American Journal of Medical Quality*, *32*(2), 117–121. https://doi.org/10.1177/1062860615618783** |
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| Objective | To develop a resource to assist primary care practices to select and implement approaches to integrating mental health care into primary care settings |
| Methodology | Input from various stakeholders, including a peer specialist, experts in primary care and policy makers informed the development of a ‘Behavioural Health Integration Implementation Guide' and ‘GROW Pathway Planning Worksheet’ |
| Model | Integrated care |
| Location | USA |
| Limitations | not a program evaluation but included due to usefulness of worksheet and associated resources |

| Program details | Outcomes | Barriers/Enablers | Implications |
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| Expert review group prioritised a tool that primary care providers could use to actualise a path towards integration that was not limited to a specific model. A planning worksheet was developed to assess goals, resources, options and workflow. This article describes the method of developing the tool and the GROW tool itself. | | Argues that there is no one model of integration that will fit all settings. Focus needs to be on identifying a pathway that will meet patient needs and a practices capacity and resources. | GROW worksheet a useful tool to tailor a pilot program to the needs of primary care providers |

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