



The Potential Role of Peer Support Workers in General Practice: Perspectives of Consumers, Carers, Peer Support Workers and General Practice Staff

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Received: 21 June 2025 / Accepted: 23 October 2025 / Published Online: 16 November 2025 / Published online: 16 November 2025
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Abstract

Primary care (general practice) clinics play a significant role in ongoing mental health care and assessment, treatment, and referral of people experiencing distress. Peer support workers (PSWs) are part of the growing Lived Experience workforce in many mental healthcare settings and evidence for their value is growing rapidly. Yet, this workforce is largely absent from primary care. Qualitative interviews with 10 consumers, six family carers, eight PSWs, and 14 general practice doctors, nurses and administrative staff occurred prior to a real-world trial and explored their perceptions of the potential benefits of introducing a PSW intervention for people who seek help for their mental health within primary care in Australia. Interview data were analysed thematically using Braun and Clark's six-step guide, following an inductive approach. Four themes were identified: (1) offering companionship, validation, and hope; (2) sharing learnings and providing practical support; (3) aiding in communication and offering consistency to help address service system gaps and health service navigation; and (4) redistributing power and advocacy. There was strong agreement across interviewees about potential positive impacts that PSWs could have in enhancing mental health care in primary care. These benefits require testing within primary care, given known challenges with awareness and understanding of the PSW role by other health professional disciplines in mental health settings, and differences related to how peer support and primary care practice are delivered. Overall, these perspectives and the existing evidence suggest that peer support may lead to more responsive, safe, effective, and person-centred primary mental health care.

Keywords Primary care · Mental health · Lived experience · Peer support workers · Early intervention · Qualitative

Introduction

Primary care settings and providers such as general practitioners (GPs, also known as family physicians), nurses, and psychologists, deliver first-contact, accessible, comprehensive, and coordinated mental health care to large segments of the population. These providers are often the first point of help-seeking, contact, and mental health assessment for people experiencing distress, making them vital mental health supports (Parker et al., 2021). A multi-tiered stepped-care approach across the life course is facilitated through primary care in Australia, regardless of age or stage of mental health.

As a result, primary care providers are often the principal referrers to community supports and other parts of the mental health system. From 2020–22, one in five (or 4.3 million) Australians aged 16–85 years reported having experienced a mental health condition lasting more than 12 months. Of these, 1.9 million (45.1%) saw a health professional such as a GP (35.5%) or psychologist (21.3%) for their mental health (Australian Bureau of Statistics, 2023).

Shortages in the health workforce and rising healthcare demands are persistent and global problems that impact the availability and quality of care. These challenges are particularly experienced within the primary care sector, stemming

from: an ageing population; increasingly complex health needs; and complex health care systems for patients, their families and service providers to navigate. Further challenges include: post-COVID-19 impact on community mental health; increases in frequency and intensity of natural disasters (e.g. bushfires and floods) due to climate change; funding constraints; and a shrinking workforce, particularly in rural and remote areas of Australia (Commonwealth of Australia, 2024). In this context, there have been calls to develop new approaches to both early intervention supports for people with emerging mental health conditions, and more holistic support to people with established mental health conditions.

Within Australia and many other countries, peer support workers (PSWs) who have lived experience of either managing their own mental health conditions and recovery or as family, carer, or kin providing support to a loved one, are increasingly employed in paid roles across mental health care settings.¹ PSWs intentionally build their lived ‘expertise’, a term used to recognise the value associated with their unique contributions, not learned through theoretical concept but based on real-life experience (Sartor, 2023; Vázquez et al., 2023). It includes experiential learning from individual experiences, as well as connection to Lived Experience² communities and being informed by Lived Experience-led research and training (Byrne & Roennfeldt, 2024). PSWs use their lived expertise for the benefit of others, providing support to people presenting to services in distress, living with mental health conditions or their family, carers, or kin. The work of PSWs is distinct from other disciplines in the Health Services, and is guided by the principles of mutuality, equality, and reciprocity (Gillard et al., 2022b; Roennfeldt & Byrne, 2021). Evidence is growing in support of the effectiveness of peer support in promoting better outcomes for people accessing services, as is information about the various enablers and barriers to their inclusion alongside existing workforces (Lawn et al., 2024a; Mutschler et al., 2022).

Currently, PSWs are employed in various public and non-government secondary and tertiary settings (Chinman et al., 2014; Corrigan et al., 2022). This includes, but

is not limited to, emergency departments (Brasier et al., 2022), hospital avoidance and early discharge (Corrigan et al., 2022; Doughty & Tse, 2011; Pitt et al., 2013; Repper & Carter, 2011), suicide prevention programs (Bowersox et al., 2021; Schlichthorst et al., 2020), young people (De Beers et al., 2024; Murphy et al., 2024), consumer-led services (Doughty & Tse, 2011), homelessness and problem substance use (Miler et al., 2020), and community mental health services (Simmons et al., 2020). A recent Australian report commissioned by the Australian Government to inform health workforce policy and reform established the acceptability, feasibility, and effectiveness of peer support in preventing hospital admissions, lowering re-presentations, and reducing costs (Lawn et al., 2024a). Further, international randomised controlled trials (RCTs) (Gillard et al., 2022a, 2022b; Simpson et al., 2014) and systematic reviews (Lyons et al., 2021; White et al., 2020) have confirmed the effectiveness of peer support in acute care settings by demonstrating improved psychosocial, care, and clinical outcomes. A review of RCTs across diverse setting types (Lloyd-Evans et al., 2014) found mixed results, largely due to heterogeneity in methods and contexts, small sample sizes, and deficiencies in reporting. However, it did find positive effects on measures of hope, recovery and empowerment. Existing evidence suggests that peer support is a responsive, safe, effective, and person-centred form of mental health care. It therefore has significant potential to help address the challenges of providing mental health support in the community. However, PSWs remain largely absent from primary care workforces, the reasons for which have yet to be explored. This may be partially explained by a lack of awareness of PSWs’ role among the general public, the small size of the peer workforce, GPs’ lack of awareness of PSWs, or some other reason. For example, recent research involving a nationally representative sample of 812 Australians has indicated that only a small number (9.2%, $n=75$) had accessed a PSW at any level of care, and over half (55%, $n=448$) were not aware they existed (Banfield et al., 2022). Research has also found a lack of understanding of the PSW roles from funders and those managing services (Roennfeldt & Byrne, 2020).

In response to the growing evidence, challenges, and opportunities, a trial examining the implementation of a lived experience ‘Peer Support intervention for those accessing mental health care in Primary Care’ (PS-PC) was co-designed with people with lived experience (consumers, carers, and PSWs) and service managers in primary care and non-government psychosocial support services, to be piloted in four general practices across Australia (Lawn et al., 2024b). This paper reflects on the potential perceived benefits of introducing the PS-PC intervention within the

¹ For the purposes of this paper, the term PSW is used to include consumer and family/carer peer workers i.e., individuals providing peer support within a designed Lived Experience role as either a person with personal lived experience or a lived experience of supporting another person experiencing mental health challenges (see Byrne et al., 2021 for further detail).

² This style aligns with advice and preference as set by the Australian Lived Experience (Peer) Workforce Development Guidelines (Byrne et al., 2021) which state: “The term ‘Lived Experience’ when referring to roles or the workforce, is capitalised to distinguish the professional from the personal, i.e. working in a Lived Experience role as opposed to ‘having a lived experience’.”

primary care setting, as reported by these multiple stakeholders prior to the commencement of the trial in primary care.

The aims of the study were: (1) to understand the experiences of consumers and family carers currently receiving mental health support in the primary care setting and to explore their perceptions of the potential for PSWs being involved in this journey, (2) to explore, with PSWs, the potential for their role in providing peer support to people experiencing mental health challenges within primary care; and (3) to understand the experiences of general practice staff in providing services to people in their community and to explore their perceptions of the potential for PSWs to provide support to people connecting with their primary care clinics for support with mental health challenges.

Methods

Study Design and Setting

This qualitative study formed a preliminary step in a broader project focused on co-designing and then trialling a peer support intervention for mental health service users in four Australian primary care clinics (Lawn et al., 2024b). Situated within a constructivist–interpretivist paradigm, the study used semi-structured interviews with a purposively selected sample of consumers, family carers, PSWs, and general practice staff, exploring their perspectives on the potential mental health support that PSWs might provide within a general practice context. Constructivists view meaning as emerging from exploring a phenomenon within its context and through engagement with the data; therefore, this approach was deemed the most suitable (Ponterotto, 2005).

This study adhered to the guidelines outlined in the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007—see additional file 1).

Ethical Considerations

Ethics approval was secured from the Flinders Human Research Ethics Committee at Flinders University (No.6034). A Participant Information Sheet, outlining the study information, was provided to all potential Lived Experience participants as part of the invitation sent by Lived Experience Australia to its national network. Similarly, a Participant Information Sheet was provided to staff in each general practice clinic; distributed electronically to all staff via regular internal communications by the practice manager. Informed consent was obtained from all Lived

Experience and general practice staff participants by either the lead researcher or the project coordinator.

Study Setting

Interviews with general practice staff were conducted across the three Australian rural general practices (n=2 in South Australia and n=1 in Queensland) that had agreed to participate in the planned intervention, and which had signed up to be involved in the trial (the fourth clinic was still considering participation at that time). Each general practice clinic employed between 2–10 administrative staff, 2–7 nurses, 1 practice manager, and 6–9 GPs. The general practices were located between 1.5 to 3.5 h drive away from a major metropolitan centre and its services, and served communities with population catchments of between 7000 and 11,000 people.

Participants and Recruitment

General Practice Staff

Practice nurses, practice managers, receptionists, and GPs employed at the participating study sites were eligible to participate. Snowballing and purposive sampling were used to recruit 3–5 participants from each site. Initially, the project coordinator (BF) contacted practice managers at each site to schedule an interview. Subsequently, practice managers invited practice nurses, GPs, and reception staff who were willing and available for interviews and coordinated a convenient time for each staff member with the project coordinator. No practice staff who agreed to be interviewed subsequently dropped out.

Consumers, Family Carers, and PSWs

Consumer and family carer participants were recruited via a dedicated electronic e-news invitation to a network of approximately 10,000 people associated with the national advocacy organisation Lived Experience Australia, sent by its operations manager (CK), with the request to send expressions of interest (EOIs) to the lead researcher (SL) via email. This process aimed to minimise any perceived undue influence during recruitment, as highlighted by the University HREC that reviewed the study, due to SL being the University-based lead researcher and also Executive Director of Lived Experience Australia. Participants were not personally known to the researchers who interviewed them prior to their recruitment, ensuring that any potential bias was minimised. Interview eligibility required: lived experience of mental illness, either as a consumer or family

member, carer, or kin; and having sought mental health support from a primary care provider. Individuals with experience as a PSW within mental health services of any kind were also sought, though this was not a requirement for participation. PSW participants were recruited from the same pool as the consumer and family carer participants (i.e., from Lived Experience Australia's national network that includes both consumers and family carers, some who also identify as PSWs). The research team were also interested in hearing from individuals who, as part of their contact with general practice, may have experience with a GP Mental Health Care Plan (Services Australia, 2024) and if they were located in a rural or regional area. Approximately 80 individuals responded to the EOI within the first two days of recruitment, with additional responses received over the following two weeks. The lead researcher used purposive sampling to select participants based on information provided in the EOI to ensure diversity in age, gender, location and lived experience. No Lived Experience individuals who agreed to be interviewed subsequently dropped out.

Reflexive Comments

This research was undertaken by a large team comprising researchers drawn from diverse disciplines and research contexts (Lived Experience, medicine, nursing, social work, public health, rural, health services research, primary care). The research team collaborated with a large group of community partners from diverse organisations involved in the delivery of primary care or psychosocial peer support (clinical, community-based non-clinical mental health and psychosocial disability support, Lived Experience advocacy, Lived Experience peer support education and training). This combined team formed the large Project Reference Group (PRG) which was also diverse in age, gender, and length of experience and expertise in their respective roles. Issues of power and potential inequity of voice across the PRG discussions and project decision-making processes, more broadly, were well-managed with respect for all contributions through the lead researcher (SL) and project coordinator (BF) modelling collaborative Lived Experience peer values of mutuality, equality, reciprocity, and authentic co-design in all PRG interactions.

All interviews were conducted by researchers (BF and SL) who have lived experience of mental health challenges, have supported others on their journeys as carers, and identify as Lived Experience researchers. BF conducted all interviews with general practice staff, and SL conducted all interviews with Lived Experience participants. All researchers involved in coding and preliminary development of themes identified as female, had a PhD, and had varying levels of qualitative research experience which included an

early carer researcher (BF), a mid-career researcher (MR), and senior research professor (SL). This diversity enhanced the analyses discussions.

Several members of the broader research team have lived experience of mental health challenges, though they were not contributing explicitly to the research from this perspective. Several community partners in the research identified as Lived Experience advocates or allies. They were members of the PRG and are listed as authors on this paper, with their permission, given their significant role in conceptualising the study, their contributions to data synthesis, and meeting other criteria for authorship. Like several of the community partners, SL has also been instrumental in systemic advocacy in the mental health sector and promoting the growth of mental health Lived Experience networks and peer workforce across Australia. Any perceived bias across the project team was managed through robust PRG discussion.

Data Collection

Two semi-structured interview guides were developed in consultation with the PRG of researchers and community partners. A brief easy-to-read definition of the peer work role, drawn from the Australian national guidelines (Byrne et al., 2021) and including a summary of the values and principles from which PSWs deliver their role, examples of settings in which they work, and what they do in those roles, was provided to participants at the beginning of the interview process. This was especially useful for general practice staff, many who were unfamiliar with the role. In contrast, participants with lived experience had awareness of the role, ranging from some to a lot. All participants were aware of the interviewers' status as Lived Experience researchers. This was important for transparency, and for building trust and rapport.

The guide used to interview Lived Experience participants (see additional file 2) was based on the Your Experience of Service (YES) survey (AMHOCN, 2024), which is widely used in mental health services across Australia. Lived Experience participants were asked about their prior experiences of receiving mental health supports (e.g., respect shown, safety in seeking help, family involvement) and how they felt about those experiences, barriers and enablers to accessing that support, and what would have made their experiences better. The guide used to interview general practice staff (see additional file 3) was informed by the Theoretical Domains Framework (TDF) (Cane et al., 2012) to gain insights into their perspectives on providing mental health support in general practice. These domains included asking general practice staff about their mental health knowledge, skills, usual practice, beliefs about their capabilities, motivations, and environmental context and

resources for delivering mental health care. In the context of their responses to these questions, both guides also explored participants' perceptions of the potential for receiving or providing mental health peer support in the primary care setting, and what barriers and benefits there might be to inclusion of the peer work role in this setting. The interview guides were pilot tested with community partner members of the PRG.

Different interviewers were used to accommodate scheduling. All interviews with Lived Experience participants were conducted individually by the lead researcher (SL) between April and May 2023 using videoconferencing (Microsoft Teams classic, V1.6) or telephone. The interviews lasted between 30 and 70 min. General practice staff interviews were conducted by the project coordinator (BF) between June and September 2023, also via videoconferencing (Microsoft Teams classic, V1.6) at a mutually convenient time during their work day. These interviews lasted between 30 and 60 min, with most participants joining from private offices at their workplace. Both interviewers made brief reflective notes at the end of each interview. All interviews were transcribed verbatim for analysis using Otter.ai and then cross-checked for accuracy. Lived Experience participants were offered the opportunity to review their transcript; however, none elected to do so. While general practice staff participants were not offered the opportunity to review their transcript, they could review the consolidated findings, including themes, codes, and quotes. One participant chose to take advantage of this opportunity and provided feedback, expanding on their interview comments which were then included in the data for analysis.

Remuneration for Participation

To thank them for their time, Lived Experience participants received a \$40 honorarium. Each general practice was paid \$100 per staff member interviewed, given that interviews occurred during their work hours, and because this type of payment for involvement in research is expected in this setting.

Data Analysis

The transcripts underwent inductive thematic analysis following Braun and Clark's six-step guide (2006). Throughout this process, one author (MR) listened to the recordings, immersed themselves in the transcripts, manually coded each interview using word processing software, and analysed the data, consistently referring to raw data to substantiate emerging ideas and themes. Other members of the research team (BF, SL) became familiar with the interviews by listening to the recordings, checking transcripts, open

coding a sample of 10% of the interviews, and discussing this process with the primary coder in order to inform the overall coding of interviews and team discussions about analyses. Labelling of themes and subthemes was discussed among the research team during regular meetings until a consensus on tentative themes was reached, ready for presenting to the PRG and wider members of the research team. A coding tree is available from the corresponding author by request. To enhance trustworthiness and mitigate threats to validity, strategies outlined by Lincoln and Guba (1985) were implemented. For example, an audit trail of the analysis process was maintained and detailed, in-depth descriptive data, including rich verbatim quotes from participants, are presented throughout the results to fulfill criteria for transferability and confirmability, respectively. Reflexivity was practiced during the study by the researchers involved in coding data keeping memos to enhance the team discussions about analyses, and by discussing the tentative themes and seeking PRG and wider research team members' feedback prior to finalising the themes.

Results

Ten consumers, six family/carers, eight PSWs and 14 general practice staff were interviewed (see Tables 1 and 2). The 24 Lived Experience participants were drawn from across Australia; 20 were female and age range varied (20 s–60 s; median consumer and family carer age=30 s and median PSW age=50 s). Several identified across multiple roles (consumer, carer, PSW); therefore, during interviews, they were asked to choose the one role they most strongly identified with and speak specifically from that experience. Half of the PSWs were in more senior coordinator roles. The general practice staff participants included four GPs (3 male, 1 female), three practice managers, four nurses, and three reception staff (all of whom identified as female). Other demographic details were not collected for general practice staff participants, to preserve anonymity within the clinics.

Participants with lived experience either reflected on their experiences with receiving mental health care in general practice settings, or they spoke about their previous experiences with receiving support (including peer support) in various environments. They then considered how a PSW might have enhanced their experience if they had been available to them in a general practice setting. General practice staff participants reflected on providing services to people in their community and their perceptions of PSWs providing support to people experiencing mental illness who connect with their general practice clinic.

Four themes are described below, with direct quotes from participants provided in Table 3 to illustrate each theme,

Table 1 Lived experience participant demographic information

Consumer participants					
	Gender	Age	Location #	LE Status	
1	Male	50 s	Regional QLD	+ Carer	
2	Female	60 s	Regional NT	+ PSW	
3	Female	50 s	Metro WA	+ Carer/+ PSW	
4	Female	30 s	Regional QLD	+ PSW	
5	Female	30 s	Regional TAS		
6	Female	30 s	Regional NSW		
7	Female	30 s	Metro QLD		
8	Male	50 s	Regional TAS		
9	Female	20 s	Metro NSW		
10	Male	60 s	Metro NSW		
Family/Carer/Kin participants					
	Gender	Age	Location	+ LE Status	
1	Female	50 s	Regional NSW		
2	Female	60 s	Metro TAS	+ Consumer	
3	Female	50 s	Regional NSW	+ Consumer	
4	Female	30 s	Metro VIC		
5	Female	60 s	Metro VIC		
6	Female	60 s	Regional QLD		
Peer support worker participants					
	Gender	Age	Location	LE status	Employment role
1	Female	60 s	Regional QLD	+ consumer /+ carer	Peer Support Worker (PSW)
2	Female	30 s	Regional NSW	+ consumer /+ carer	Recovery Coach (RC)
3	Female	30 s	Metro QLD	+ consumer	Peer Work (PW) Coordinator
4	Male	40 s	Metro VIC	+ consumer /+ carer	PSW
5	Female	40 s	Metro VIC	+ consumer /+ carer	Volunteering
6	Female	40 s	Metro NSW	+ consumer /+ carer	PW Coordinator
7	Female	50 s	Regional QLD	+ consumer /+ carer	PW Coordinator/RC
8	Female	50 s	Metro NSW	+ consumer /+ carer	PW Coordinator

[#] NSW-New South Wales, NT-Northern Territory, QLD-Queensland, SA-South Australia, TAS-Tasmania, VIC-Victoria, WA-Western Australia

using generic identifiers for each participant type (P=lived experience participant; S=staff participant; then information to denote their status as consumer, carer, PSW or staff type). For noting in this results section, the term ‘participant’ was used when the subtheme being described included data from all participant groups; it served as a collective term to summarise input from Lived Experience participants and general practice staff. In contrast, when data were drawn from specific groups only, we have used more precise terminology, such as “consumers”, “carers”, “staff”, or “peer workers” to reflect the source of the data.

Table 2 Demographic summary: general practice staff

No	Clinic (No.1,2,3)	Role	Gender (M= male; F=Female)
1	1	GP	M
2	1	Practice Manager	F
3	1	Nurse	F
4	1	Nurse	F
5	1	Reception	F
6	2	GP	M
2	2	Practice Manager	F
8	2	Nurse	F
9	2	Reception	F
10	3	GP	M
11	3	GP	F
12	3	Practice Manager	F
13	3	Nurse	F
14	3	Reception	F

Offering Companionship, Validation, and Hope

Validating Feelings and Offering an Ear

Many participants in this study highlighted the significance of understanding individuals' perspectives around the incredibly personal and often isolating experiences associated with mental health challenges. PSWs were seen as playing a vital role in helping consumers and carers feel understood during vulnerable moments due to common experiences—or having “*struggled*” themselves—thereby reassuring them that they are not alone. The unique empathy and understanding that PSWs could bring to the interactions were emphasised as it provided individuals a sense of validation and normalcy. Staff, in particular, recognised the “*huge value in just listening*” [S08, Nurse] as consumers shared their stories or vented. Yet, despite acknowledging the necessity of listening, time constraints often hindered staff’s ability to provide this support in general practice. As such, making PSWs available to support consumers, either in the practice or outside of it, was seen as important, especially for those who feel lonely and in need of someone with whom to share. Staff also highlighted how valuable it would be to have someone with lived experience (such as a PSW) available to listen to and validate consumers' perspectives.

Providing Hope and Facilitating Acceptance

Many consumer participants, in particular, shared the hurdles they faced across various aspects of their mental health journey, highlighting the difficulty envisioning a path forward. As such, inspiring hope and assistance for consumers and carers in understanding and accepting various aspects of their recovery journey was seen as a unique part of the PSW role. Many consumers emphasised how someone who has

overcome similar challenges can offer reassurance, instilling hope that their current circumstances will improve. For instance, a consumer [P03] expressed how access to a PSW could have enhanced their mental health journey by offering reassurance that their current struggles were “*not forever*”, valuing the importance of “*real-life examples*” in fostering hope. Additionally, PSWs were seen as playing a vital role in facilitating self-awareness and overcoming barriers to acceptance, whether in accepting a diagnosis or helping them to sort through any emotions that might be preventing them from helping themselves. For example, reflecting on their own journey, one consumer [P05] believed that a PSW who could have heard their “*objections*” to a mental health diagnosis could have been beneficial. They suggested that a PSW sharing personal experiences may have enabled them to draw their own conclusions, possibly leading to earlier engagement with services and support. Similarly, another consumer [P03] believed a PSW could have helped them be “*a bit gentler*” on themselves and could have helped silence the “*strong inner critic*” that was preventing them from accessing the mental health support they needed.

Walking/Sitting Alongside

Participants across all groups acknowledged the importance of companionship and support throughout any mental health journey; and not being alone with their mental health struggles. However, some acknowledged that individuals with mental health challenges may prefer not to involve those closest to them (family or kin); or they may lack that option altogether. As such, many participants identified the role that PSWs could play in offering this support. The concept of ‘walking/sitting alongside’ emerged as a metaphor describing how PSWs can support individuals by accompanying them through their mental health journey. PSWs were perceived as valuable allies who could sit with the person during anxious moments, such as in the waiting room or taking a walk before their appointment, to ease anxiety. This presence could offer a sense of solidarity and comfort, alleviating feelings of isolation and unease before, during or after their appointment. As one carer [P02] recounted, having a PSW sit and talk with them in a different setting made them feel “*really at peace*”.

Sharing Learnings and Providing Practical Support

Preparing for What to Expect

Consumers and carers expressed frustration with the uncertainty of the mental health process and the repetitive nature of recounting their stories when seeking mental health services. As such, participants from all groups emphasised

the vital role of PSWs in assisting individuals to prepare for mental health discussions, managing expectations and anxiety before GP and other mental health appointments, and improving the appointment experience for consumers, carers, and staff. For instance, participants stressed the importance of PSWs potentially helping consumers and carers formulate questions for staff, document their stories, or discuss the different options that may be available to them as part of improving overall health literacy. Such tangible and active support strategies could streamline communication by easing the burden on staff given the time constraints experienced in general practice appointments. PSWs sharing their own recovery story could also enhance consumer and carer readiness and confidence to engage with GPs.

Sharing Knowledge and Guiding

Frustration was expressed by participants across all groups regarding the lack of information and the overwhelming number of choices when navigating the mental health system. Participants emphasised how PSWs can aim to “*speed up the learning process*” [P06, Carer] by providing practical guidance about the complex mental health care system and connecting individuals with external services after seeing a GP. The value of a PSW’s firsthand accounts of effective services went beyond information dissemination (e.g., available services and referral pathways), for consumers and carers desiring further tailored guidance. For instance, some participants mentioned the potential of PSWs, presenting the pros and cons of different pathways from their perspective, and suggesting suitable services aligned with the needs of individuals. Furthermore, some participants also noted how PSWs could act as sounding boards after appointments, aiding individuals in processing their experiences and making informed decisions about their ongoing care. The ability of PSWs to guide consumers and carers stemmed from participants recognising PSWs’ firsthand experience in navigating the system, coupled with an understanding that PSWs are continuously learning in this domain.

Offering Practical Assistance and Interim Support

Many participants, particularly staff and PSWs, acknowledged how healthcare appointments and assessment paperwork could be overwhelming, particularly for those with mental health issues. As such, PSWs were seen as capable and useful supports during various practical tasks (e.g., filling out forms, ensuring a wellness plan is in place, following up on tasks, booking appointments in advance, supporting attendance at appointments). Practical support also extended to having a physical presence in appointments where PSWs could potentially “*write things down*,” [P12, PSW], while

Table 3 Participant quotes to illustrate themes

Theme	Subtheme	Quotes #
1. Offering companionship, validation and hope	1.1 Validating feelings and offering an ear	“I think having someone that can validate, and actually just sit with and say I hear you, I see you is so empowering, because it's not always about what someone says it's about ... how you make them feel. And I know if I had that 15 years ago, 20 years ago, instead of my mum dragging me when you know, to a mental health hospital when I was in distress, I do often wonder if that would have changed my pathway through my teenage and early adulthood.” (P16, Consumer and Carer) “I think it would just encourage people to attend and feel more comfortable that they know they're not doing it alone. Because I think that that's yeah, one of those things. I think, if you're in that state, you think you're the only person that's ever gone through those problems before and no one's ever gonna understand. But if you're bringing someone that's been through that or something similar to you, then I think that in itself would make a huge difference, for sure.” (S13, Receptionist) “Sometimes they just want somebody to talk to ... we have some patients that ... come in here for mental health and they just come to the front desk and they kind of have a chat and then literally just walk out ... there are regular patients that book in all the time because sometimes they just want to chat.” (S12, Receptionist)
	1.2 Providing hope and facilitating acceptance	“But you know, unless you've suffered with a mental health issue, you sort of you can't really understand what they're going through. So somebody that has ... like sorted that and they're doing well, would have to only be a positive for them, as well, you know, gives them hope as well, that ... they can live the same kind of life.” (S09, Practice Manager) “It would have would have given me some hope as well, because I wondered how I was going to get out of this mess. I mean, so I think just being able to know somebody else had found their way through a similar period would have helped in that moment as well.” (P33, Consumer) “Accepting, you don't have to accept that you have a disability, but accepting that you have needs and that it may be disability services that are called upon. And even for the carers as well, this was this was something I found is that, because things are called carer services, and they don't view themselves as a carer that the services that are there, that would be helpful, but they're not willing to accept them, because they don't view themselves as the person who should be receiving them? I think that's where either consumer or carers, peers can be very helpful with it sort of helping break down that barrier, saying, ‘Well, you know, you don't have to accept this label. But you do meet this criteria, and it is there for you.’” (P24, Consumer)
	1.3 Walking/sitting alongside	“There's times when I've struggled even just to get just there (to the appointment). And then you're sitting there waiting in a waiting room, and you're kinda like, you don't want to be there because you just want to curl up in a ball and cry. But there's no one there that can even just sit with you. And I've found that too, in my role as a Peer Support Worker, sometimes, people don't want you to do anything for them. They just want someone else there because it's so isolating.” (P20, Consumer and PSW) “I got to thinking, you know, a lot of the people that are having a crisis often don't have someone to be with them [then add in if they have] anxiety and the doctor is running late, being able to care for that person outside and help them understand that they need to just be patient [would be helpful]. Because usually, by the afternoon, the day is quite late and even though everyone works hard to keep the doctors on time, it doesn't always happen like that. So yeah, just having that person with them while they're waiting so that they don't storm out. Which I think is what happens sometimes because that the person feels that they need help, and they perceive it as not happening, just because maybe it's 40 min after the appointment time.” (S02, Nurse)
2. Sharing learnings and providing practical support	2.1 Preparing for what to expect	“If there was a peer worker available, before I went to see a psychologist or got into see a psychologist, it would have helped. I think a lot of groundwork could have happened. And then you get the most out of the time. (P35, Consumer and PSW) “Having to share that story over and over and over again, is very frustrating ... A Peer Worker could have ... let me know ‘that when you start trying to ring around, this is what you're going to face, it's going to be incredibly difficult. You might be on hold, or they might call you back tomorrow, or they might not call you back at all.’” (P19, Carer)
	2.2 Sharing knowledge and guiding	“I think having somebody who's possibly been through that experience already, who has their own learnings that they can impart to you. Because I think there were situations where I stuck around for a lot longer because I thought, Ah, I don't know if there's anything better out there or if ... anybody else is going to treat me differently, particularly with psychologists or psychiatrists, ... [or if there is] somebody else who you can talk to. Like, is this normal? Is this you know, is this something that I should be putting up with?” (P08, Consumer) “If we'd had somebody to explain the system, and who to go to in different situations ... especially the first time, you know, what's going on. And it takes a long time to get to know the system and, and the people in it.” (P21, Carer)

Table 3 (continued)

Theme	Subtheme	Quotes #
	2.3 Offering practical assistance and interim support	“Things are overwhelming for people with mental illness... I think a Peer Worker can help in that regard; they can help follow up... [and] they can prompt you ... Because, you know, self-care is, you know, everyone struggles with it. And I think Peer Workers could really help with those things that we just let slip.” (P07, Consumer) “I suppose making sure that appointments are scheduled and attended and those sorts of things. Because that's where a lot of our follow up is ... anytime there's missed appointments, with mental health people it is just trying to catch up from then onwards, because then we know that they miss scripts, they miss medications... So if there's somebody there that can deliver that, remind them, you don't want to be their micromanager. But sometimes they do need it.” (S04, Nurse) “Whilst they're waiting for the referral to be off and accepted by the care provider, if the Peer Worker was kind of introduced fairly soon at the start of the process ... they might be able to get, you know, two weeks to have those sessions in before they actually get to their third-party referral. So you know, that just might keep them a little bit hopeful and engaged... [and] they're not just kind of being sent home and told 'oh we sent off the referral and now you've just got to wait'.” (S01, Practice Manager)
3. Aiding in communication and offering consistency	3.1 Interpreting feelings, deciphering language and translating	“I think peer workers act as intermediaries almost like negotiators between or even translators between, yeah, they have translate the person's fears or apprehension and then they have to try and translate the clinician speak into language that that person is going to feel trusting of and accept... Not try to paint a different picture, but paint the same picture a different way.” (P35, PSW and Consumer) “GPs tend to talk a lot of jargon as well. So be, you know, simplify the language as well. But also yeah just to kind of, I guess, communicate, you know, between the two that, you know, for example, going into a GP practice and not really knowing how to explain what is going on for you, whereas you can, yeah would be able to kind of speak to a Peer Worker, and they'd kind of be able to, I guess communicate, not for you, but like on, you know, with you in, you know, kind of what you need.” (P06, Consumer and PSW)
	3.2 Acting as a conduit and a consistent point of care	“There are times when, you know, mum may not feel comfortable telling the GP about some things, or she may forget. Whereas the peer worker, you know, when it's getting towards the end of the of the appointment, the peer worker could bring these things up. And then just be the voice in between, you know, for mum and I, so that the worker, could you know, you know, relate back to me, you know, this is what's happened, this is the next goal plan, X, Y Z needs to happen.” (P26, Carer) “They [the Peer Worker] might be able to communicate with my family, help them understand what I'm going through better. Be a bridge between them. Also, be able to communicate [to them] their lived experience and what I found helpful. And that recovery is different for every person, what it looks like, and what it entails. So yeah, just that lived experience that they can convey [to my family].” (P15, Consumer and PSW) “They [Peer Workers] can often be the glue that binds different people together the consistent thread between different carers. They can connect people with NGOs and external resources, which are usually very effective. They can connect people with... like exercise groups or gym classes or group stuff or, you know, online YouTube courses or whatever it is to improve people's wellbeing.” (S10, GP) “If we had someone that could actually check in on them rather than us seeing them in two or three weeks, we might see them four or five weeks, because you know, you've got the backup and someone there that can be a point of call, whereas if they've got nothing. And their coping skills are minimal. And you know, there's no services, and they're waiting for counselling, because they want medication, you go, well, I probably need to check on your more often.” (S06, GP) “[A Peer Worker may] make them [staff] accountable. You know, because when you haven't got someone by your side, and you're just, I won't say mistreated, but not well treated... They're not accountable to anyone. No one else is seeing it.” (P13, Consumer) “What would make me feel welcome and safe... I guess, would be having external views of what's going on [which a Peer Worker could do] ... I won't engage with the mental health services... unless I have a support person present... somebody who can witness what is being said and.. make observations of my behaviour.” (P01, Consumer)
4. Redistributing power and advocacy	4.1 Providing witness support and having someone on side	

Table 3 (continued)

Theme	Subtheme	Quotes #
	4.2 Advocating and supporting assertiveness	“If there was someone there that understood what was happening and could advocate, because sometimes you’re in a state of mind where you don’t have a voice, because you, you know, you’re so depressed... yeah, having someone there that can be a voice I guess, in those times when you may not feel like you have one.” (P20, Consumer and PSW) “For me a Peer Worker as a really good space for an individual who might not have good family support... to bounce those ideas off and come up with a way forward and to help you sit down with family if you have difficult family. Especially the controlling sort who wants to know everything about you or run your care for you. I think having a Peer Worker in there to... just be there to help you stand up to family and go no, this is what I want.” (P11, Consumer and PSW) “What stopped me from being completely honest, was fear and just a lack of knowledge about how the mental system worked. Whether if I said A, B or C, was I going to be locked up? Because I’ve never been... I’ve never experienced your help before. And so I think, if I had a peer to talk to you, and that would say, ‘No, no, no, that that’s not how it works, you don’t yeah that’s the movies.’” (P35, PSW and Consumer) “I think mainly, having somebody outside of a clinical setting that the patient can trust. I think that a lot of patients probably, you know, just having somebody that they feel comfortable with, hopefully, without any kind of form of judgment or concern that obviously this is going to be on their clinical record, or, you know, that type of thing.” (S05, Practice Manager)
# A number of participants identified as holding two roles (e.g., as both PSW and identifying from a ‘consumer’ perspective). Where this is apparent, the first role identified in brackets following each quote is the one they most strongly identified with when participating in interviews		

acknowledging that “you’ve got a person who’s in a vulnerable place, who may not be thinking with their most logical rational thinking.” All participant groups to some extent expressed how valuable this role could be. However, staff were particularly emphatic on this point, seeing the potential role that PSWs could play in bridging the gap between referrals and seeing professionals as well as offering support and engagement during the interim period. This interim support was considered crucial for preparing individuals for the next step, fostering ongoing engagement in the process, and, importantly, helping them in the meantime.

Aiding in Communication and Offering Consistency

Interpreting Feelings, Deciphering Language and Translating

Many consumers explained that they experience difficulty communicating their needs and feelings clearly when they are unwell. Further, some carers acknowledged that experiencing strong emotions (e.g., upset, anger, grief, fear) can hinder their ability to provide or receive information effectively about their loved one. As such, PSWs were seen as potentially playing a role in interpreting feelings and translating complex emotions. As one PSW [P04] emphasised, PSWs can intuitively grasp what individuals are trying to convey, even when individuals cannot find the “right words” to express their struggles, due to their similar experiences. Through this ability, PSWs could potentially remind, model, or inform staff of how to act and/or help convey the requirements in that particular instance. Moreover, PSWs were seen as valuable translators between the medical jargon healthcare professionals or staff use and language that is accessible to consumers and carers, with one PSW [P08] describing how they aim to speak both medical and layperson language, acting as a bridge between staff and consumers.

Acting as a Conduit for Communication and Offering Consistency

Participants discussed how PSWs could help to address breakdowns in communication within the mental health system among various services and staff. This was especially so given the added challenges of involving family members in one’s care. Consequently, many participants emphasised the pivotal role that PSWs could play as conduits between staff (e.g., GPs, psychologists, psychiatrists), carers/family members, and individuals receiving mental health support, acting as a consistent, familiar thread amidst these different stakeholders.

Staff, in particular, recognised the crucial role PSWs could play in providing feedback for informed and coordinated care. Moreover, they noted how PSWs may be unique in acting as a consistent point of contact for consumers and providing structured management plans developed by bringing all sources of advice together. In complement, carers and consumers viewed PSWs as invaluable in engaging with family members and friends, offering explanations and bridging communication gaps. For instance, one PSW [P06] recalled an instance when they were angry (“*pissed*”) with their mother at the time and having access to a PSW helped their mother understand their condition better, an interaction appreciated by both parties. Participants also identified the role PSWs could have in obtaining information from family/carers, conveying it to staff and, in turn, updating family members/carers—with permission—on the individual’s behalf. In doing so, they recognised how engaging with family members at a vulnerable time can sometimes impact an individual’s mental health but acknowledged this had potential to be helpful and provide education for their loved ones and, in turn, be supportive of families.

Redistributing Power and Advocacy

Providing Witness Support and Having Someone on the Person’s Side

Many Lived Experience participants emphasised the crucial role of having someone who can witness and validate their experiences, particularly during consultations with health professionals in mental health settings where they have often felt unheard or ignored. Simply having another set of ears in the room was perceived as beneficial by some, as it helped to address the power imbalance that’s some carers and consumers experience. In fact, two PSWs shared previous experiences where their mere presence shifted the “*dynamic and language*” [P15] used in the mental health consultation, and that this may also be achieved in general practice if PSWs were to attend appointments with individuals. Staff also recognised the importance of individuals feeling as though they have someone on their side.

Advocating and Supporting Self-Advocacy

PSWs were discussed as potentially having a role in advocating for and supporting assertiveness and self-advocacy within mental health interactions. Some consumers and carers expressed a desire for PSWs to actively speak on their behalf if they were feeling particularly vulnerable, or to advocate on their behalf if a strong voice was required to ensure their preferences were acknowledged and respected. For instance, one consumer [P10] recounted feeling

dismissed in a previous instance and believed a PSW could have intervened by asking, “*Are you hearing what she’s saying?*” In this regard, PSWs were also mentioned as valuable resources for helping consumers and carers understand and advocate for their rights. However, others viewed PSWs as facilitating a more indirect role, aiding them in gaining confidence to articulate their feelings and assert their needs independently. For example, one consumer highlighted how PSWs could provide the necessary support for them to confidently convey their wishes to their family or staff, illustrating the role of PSWs in fostering self-assertiveness. Indeed, one PSW shared an experience where they promoted self-advocacy firsthand rather than acting as a spokesperson by encouraging a consumer to express their needs to the doctor directly.

Fostering Trust and Safety

Many consumers spoke about their struggles to be open and honest with staff, fearing how that information would be interpreted and used. As such, many consumers highlighted the critical role of PSWs in creating a safe and non-threatening environment for them to open up, especially for individuals who felt guarded or anxious about discussing their mental health concerns with staff, fearing being “*locked up*” [P02] or “*pathologised*” [P04]. One consumer explained how it had taken time for them to answer questions about their mental health honestly in the past as they have wanted to “*very carefully suss them out [i.e., subtly investigate them] to see how they [the GP] would respond first*” [P02]. However, several carers and consumers explained that other individuals might be able to trust a PSW almost immediately because they would come from “*a different power base*” [P06, Carer] with the sole purpose being to “*understand you,*” not “*diagnose you*” [P04, Consumer]. Individuals could benefit from this as PSWs might then encourage them to be open and honest before appointments and reassure them about the process, perhaps also accompanying them to their appointment to provide the “*scaffolding*” they need to feel “*safe and secure*” during consultations with staff [P10, Consumer]. This, in turn, would expedite the process for them to receive the support they need.

Discussion

The findings of this study indicate consistent agreement across multiple groups of stakeholders about the potential positive impact that PSWs could play in enhancing mental health care in the primary care context. It was evident across the four themes that these stakeholders greatly valued the core principles of mutuality, equality, and reciprocity

fundamental to the PSW role, especially when conceptualising potential supports for individuals experiencing mental health challenges.

A key theme in this study was the potential for PSWs to provide validation and hope. While important at all stages of a person's mental health experience, this support is particularly critical in the early stages of help-seeking, identification and initial diagnosis (Laranjeira & Querido, 2022). It is also important, given that an increase in suicide risk is known to be associated with the period after a person first receives a mental health diagnosis (Randall et al., 2014). PSWs were seen as capable of bringing hope for the future to individuals in this period by reinforcing the person's agency during encounters with health professionals, supporting engagement with services and self-care, and being 'the evidence' themselves that recovery from mental health challenges is possible. In being available to talk, PSWs were seen as companions who could listen or sit beside those struggling with their mental health or loneliness. These qualities within the PSW role have been repeatedly noted in the existing literature (Lawn et al., 2024a; Watson, 2017).

Beyond emotional support, participants also discussed the practical contributions PSWs could make in general practice, such as connecting people to community resources that might support prevention and early intervention for their mental health. This would be particularly valuable for people who may have low mental health literacy or awareness of the available services, as PSWs could help with understanding and navigating these complex systems as well as managing expectations (Lien et al., 2024). This is especially important in general practice as people experiencing emotional distress often access primary care because it is accessible and may be more likely to be integrated with their other healthcare needs, at a lower cost compared with other services (Funk et al., 2008; Gao et al., 2024; Lawn et al., 2021). Without general practice, people might avoid seeking help for existing mental health issues because they cannot or do not want to access other parts of the mental health system. This can be due to past adverse experiences or fears about human rights violations or coercive practices in other mental health settings (Productivity Commission, 2020; State of Victoria, 2021).

Related to the above issues of help-seeking and access, is the pertinent issue of unmet need for psychosocial support for people with mental health challenges in the community, in the context of significant gaps, fragmentation and siloes within mental health systems of care in Australia (Productivity Commission, 2020; State of Victoria, 2021), which have resonance in many countries (World Health Organisation, 2025). A recent national report to the Australia Government (Health Policy Analysis, 2024) estimated that, in Australia, 335,800 people aged 12–64 years with severe

mental illness are missing out on much needed psychosocial support services (e.g., community connection, support for service navigation, support with enhancing positive social determinants of mental health and wellbeing such as housing, employment, education and so forth). This reflects an increase of around 46,000 additional people compared to the Productivity Commission's 2019–20 estimate of 290,000 people needing psychosocial supports. In addition, a further 311,500 people aged 12–64 years with moderate mental illness are also missing out and would also benefit from psychosocial support services. Such support services could be significantly improved if staffed with PSWs. Peer support, earlier, through GP practices is therefore even more critical in this sparse landscape.

PSWs also have the potential to support families and carers in improving their mental health literacy and system awareness and navigation. The experience of frustration families and carers discussed in the current study around advocating for their loved ones is well documented, especially regarding access to services and being listened to and included in discussions (Menear et al., 2020; Walters & Petrakis, 2022). Families and carers can provide crucial input to communication by acting as a conduit or bridge between the person and healthcare professionals. Hence, peer support might be valuable in mobilising the effectiveness of family and carer support roles for those experiencing mental health challenges. Additionally, PSWs can help family/carers realise their needs for carer support and promote partnership in the primary care setting (through a Triangle of Care – GP, consumer and family/carers) (Carers Trust, 2015).

A key challenge in primary care is ensuring individuals do not fall through gaps in the system. PSWs in the current study were identified as playing a key role in improving access and engagement, particularly in supporting those individuals who struggle to access appropriate care (Kaine & Lawn, 2021; Orygen, 2020; Swerissen & Duckett, 2020). There is a growing recognition that PSWs are well-placed to be 'navigators' with people, to link between the fragmented and siloed healthcare systems, including primary care (NSW Mental Health Commission, 2023; Griswold et al., 2010). For example, a US randomised controlled trial examining access to primary care after a mental health crisis, involving 175 people recruited from an emergency department, found that those who received PSW/navigator support were statistically more likely to follow through with primary care, and that it improved coordination and person-centred mental health care in primary care (Griswold et al., 2010).

Another important function of PSWs identified in the current study was addressing real or perceived power imbalances between health professionals, consumers and families within healthcare systems. A significant finding of this study

was all stakeholder groups' openness to the PSW role; that is, no groups raised the potential for power imbalances as a concern. Practice staff in particular, seemed very open to the concept of Lived Experience support as 'logical' to a person-centred approach. This was despite not having strong awareness or understanding of the role. Of note, the potential positive benefits outlined in all four themes arose from perspectives expressed by all interview groups, including general practice staff. This is also an important finding indicating awareness of the problem of mental health support provision within the general practice system and its congruence with consumers' and family/carers' views and experiences.

Evidence supports how PSWs can help to build trust and safety during encounters with health professionals or supporting individuals to develop self-advocacy, self-agency, and confidence to speak up about their needs and preferences during these encounters (Ahad et al., 2023). A narrative review by Ahad et al. (2023) found that PSWs had an overall positive impact on engagement, particularly in helping the person to overcome the potential fear of disclosure of mental health challenges due to stigma and self-stigma.

However, and despite the many potential opportunities to include PSW roles in the primary care setting, there are several known challenges that inhibit the successful inclusion of PSWs across health settings, such as cultural resistance to and continued lack of awareness and understanding of the PSW role by other health professional disciplines and across many mental health service settings, and the pervasive stigma that is still prevalent within society and service settings (Byrne et al., 2016a, 2016b; Lawn et al., 2024a). Other potential barriers in the primary care setting relate to funding structures within Australia's tightly regulated Medical Benefits Scheme. Scope of practice and medicolegal considerations within the primary care context are also unknown. Adequate supervision, funding, training, mentoring and support are necessary to ensure PSWs work within their scope of practice, maintain the unique characteristics of being a peer in navigating role boundaries and service cultures, and continue to develop their professional identity (Adams, 2020; Byrne et al., 2016a, 2016b; Chisholm & Petrakis, 2020, 2023). Likewise, Lived Expertise-led training for staff in other roles within the setting is essential to build literacy, assist in describing PSW work accurately and to foster an inclusive workplace culture. As with other mental healthcare settings, potential enablers to inclusion of peer work in primary care likely include the role of service leaders in championing peer support initiatives as this has been found to be central to the success and sustainability of peer work (Zeng & McNamara, 2021), management exposure to peer work (Byrne et al., 2019) and

whole-of-organisation commitment, culture and practice to supporting employment of peers in multidisciplinary environments (Byrne et al., 2022). Further research is needed to investigate the many potential opportunities identified in this study; an exploratory trial of PSW within primary care is one step towards understanding whether and how these perspectives are realised, or not, in practice.

Limitations

This study has a number of important limitations worth noting. The small sample size for each participant group and the method of recruitment of consumers, family/carers and PSWs from within populations familiar with Lived Experience advocacy and PSW roles may have created a positive bias in their perspectives on the value of PSWs. The majority of participants identified as female; hence, the perspectives of men were likely underrepresented. A further limitation is that this is an Australian study and results may vary for other countries with different primary care system structures (e.g., funding, workforce, scope of practice, positioning within the larger health system), and different structures impacting the peer workforce role and progress in its development.

Conclusion

This study explored the perspectives of consumers, family/carers, PSWs and general practice staff on the potential value of including mental health peer support in primary care. Across participant groups, PSWs were considered an untapped resource that may be significantly beneficial in the primary care context by enhancing service and system navigation, addressing siloes and gaps in support, and promoting mental health recovery outcomes through validation and provision of hope to people experiencing mental health challenges. PSW practical knowledge can assist to connect the person to community supports, and may improve effective communication between parties and foster engagement. Sustained contact with PSWs may also minimise siloes within and between systems of support so that people do not fall through service gaps. Further, the potential to enhance consumer-led person-centred care through impacting power dynamics was emphasised, as PSWs can facilitate improved partnerships between primary care staff and those seeking support for mental health. Overall, these perspectives and the existing evidence suggests that peer support may lead to more responsive, safe, effective and person-centred primary mental health care.

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1007/s10488-0>

25-01479-2.

Acknowledgements We thank the participants who took part in this study for their time and also the Project Reference Group and Stakeholder Reference Group that guided the overall research, including materials used in this study. We also thank the community organisations that partnered with us for this study (Mental Illness Fellowship of Australia, Skylight Mental Health, Mental Health Coalition of South Australia, Community Mental Health Australia, TANDEM, Stride, Rural and Remote Mental Health, Australian Psychological Society, Australasian Society of Lifestyle Medicine, and the primary care clinics involved in the study). This project is supported by a peer-reviewed grant from the Australian Government Medical Research Future Fund—Consumer-Led Round (2022527). Investigators report progress to the funding body, which has no significant role in the design of the study and collection, analysis, or interpretation of data, nor in writing the manuscript.

Author Contributions All authors contributed to the study's conception and design. Material preparation, data collection and analysis were performed by SL, MR and BF. The first draft of the manuscript was written by SL, MR and BF, and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Funding The Australian Government Medical Research Future Fund—Consumer-Led Round (Grant no. 2022527).

Data Availability The data from this study cannot be shared openly due to the need to protect study participant privacy.

Declarations

Competing interests The authors declare no competing interests.

Ethics approval This study was performed in line with the principles of the Declaration of Helsinki. Approval was granted by the Ethics Committee of Flinders University (No.6034, 18 April 2023).

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Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

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