Peer Support Without Borders

Learning from Global Models to Shape Scotland’s Next Steps

How to Read this Report

This report explores how peer support has been implemented, sustained, and scaled across a range of international health and social care systems. It offers a summary of what's possible when peer and lived experience leadership is placed at the centre of mental health reform and serves as a guide for readers looking to strengthen peer support in Scotland or other local contexts.

Each country or region featured (Canada [British Columbia], Denmark, England, Ireland, New Zealand, Victoria [Australia], and Wales) has taken a distinct approach shaped by its policy environment, cultural context, and system structures. Except for England, all regions explored are broadly comparable to Scotland in terms of population, geography, or cultural identity.

Importantly, each country brings a unique experience and set of learnings that may resonate differently depending on the reader's own context, challenges, or opportunities. Some insights will feel immediately applicable; others may offer new perspectives that invite reflection, adaptation, or longer-term ambition.

There are two main ways to navigate the report:

- **For a high-level overview** of what was learned across all countries, readers can begin with the **Overall Insights and Learnings** section and the **Conclusion** at the beginning and end of the report. These highlight shared enablers, patterns of success, and common implementation challenges across diverse systems.
- **For deeper, context-specific insight**, readers can turn to the **individual country chapters**, each of which explores the enablers, barriers, and cultural conditions that shaped peer support development in that setting.

Each section can be read independently or alongside others. Whether you are shaping national policy, designing regional funding models, or building peer support at the community level, this report is intended to inform and inspire action, showing how peer support has served as a powerful driver of change across mental health systems worldwide.

Contents

Introduction

"You can be on a compulsory treatment order one moment of your life, but it's only one component of who you are... you too can be commissioner."

Peer support has emerged as a vital element of mental health systems around the world, offering a relational, rights-based, and recovery-focused approach grounded in lived experience. Across a wide range of health and social care systems, peer support roles have gained traction as both service innovations and drivers of cultural and structural change. Yet implementation remains uneven, shaped by differences in policy, funding, culture, and political will.

This report brings together comparative case studies from seven countries and jurisdictions: British Columbia (Canada), Denmark, England, Ireland, Aotearoa New Zealand, Victoria (Australia), and Wales. Each country profile explores how peer support has developed in that context, what has enabled its growth, what challenges remain, and what lessons can be drawn for other systems.

Our approach combined desk-based research, policy review, and in-depth qualitative interviews with 34 individuals involved in designing, delivering, influencing, or funding peer support. These included peer leaders and practitioners, community organisers, government officials, senior health system staff, supervisors, clinicians, and policymakers. We also engaged with individuals leading system-wide transformation and those working at the grassroots, often holding both perspectives at once.

Interviewees were drawn from inside and outside government, from urban and rural contexts, and from systems at various stages of peer support maturity. The goal was not to rate or rank countries but to identify diverse models, shared enablers, and critical learning. Each country offers its own story shaped by its political culture, health structures, advocacy history, and population needs. Together, they provide a rich landscape of insights.

The report is structured into country-specific profiles and overarching synthesis sections. While country chapters offer contextual depth, the synthesis sections allow readers to understand cross-cutting lessons, offering insight into what enables peer support to grow, thrive, and remain accountable to its values across contexts.

Overall Insights and Learnings

Shared enablers and patterns in peer support across countries

This section draws together and synthesises cross-country insights from interviews and documentation spanning Canada (British Colombia), Denmark, England, Ireland, Aotearoa New Zealand, Australia (Victoria), and Wales. Despite diverse policy contexts and healthcare systems, several shared drivers and enablers consistently emerged across jurisdictions that have made meaningful progress in embedding peer support. These insights reflect not only what has helped peer support to thrive, but also the recurring challenges and tensions systems must navigate to embed it with integrity and sustainability.

1. **Strategic anchoring accelerates growth**

When peer support is formally embedded in strategies, plans, or legislative reform, it gains both legitimacy and protection. Systems that treated peer support as central, not discretionary, saw faster impact, clearer governance, more consistent, high quality peer practice and less turnover of staff. Strategic anchoring shifts peer work from a "nice to have" innovation to a core workforce and system change lever.

Example: In Victoria, the Royal Commission embedded lived experience roles across governance, delivery, and system oversight, unlocking substantial structural change. In Wales, Actions 18 and 19 of the Health Education and Improvement Wales (HEIW) and Social Care Wales Strategic Workforce Plan has given peer support formal recognition.

2. **Named peer or lived experience leaders drives system change**

Visible and senior leaders of peer support particularly those embedded in governance, government, or clinical leadership acted as change agents across systems. These individuals did more than deliver services; they advocated, mentored, designed policy, and modelled new forms of leadership. Their presence often helped overcome resistance, broker cross-sector trust, and create legitimacy.

Example: Poul Nyrup Rasmussen in Demark, Maggie Toko's leadership in Victoria, Julie Repper's leadership in England, helped elevate peer support from frontline service to a whole-system influence. In Wales and Aotearoa New Zealand, small numbers of well-placed peer leaders catalysed large-scale transformation. In Demark ex-politicians supercharged the adoption of peer practices in the medical system.

3. **Workforce planning, career pathways, and peer-led infrastructure are essential**

In regions of England and elsewhere early implementation efforts often created peer roles without investing in the supporting ecosystem, a situation they are now trying to address. This initial decision has led to burnout, role drift, and fragility. Countries that built tailored infrastructure such as peer-specific supervision, training, leadership pathways, and evaluation tools, enabled more sustainable, high-integrity roles.

Example: NHS Tyne, Esk and Wear Valley Trust in England prioritised organisational peer support readiness and infrastructure over rapid hiring of frontline peer staff. They now have over 50 peer support paid staff members with a 71% retention after three years, far surpassing comparable programmes nationally and internationally.

4. **Peer support is a cultural lever, not just a service**

Peer support creates the greatest transformation when treated not simply as a support service, but as a driver of cultural and systemic change. Organisations that embraced peer values (mutuality, choice, hope, and rights) used peer support to challenge paternalism, centre lived experience, and model trauma-informed approaches. Systems that positioned peer work as a clinical enhancement alone struggled to realise its transformative potential.

Example: NHS Trusts in England used peer-led recovery colleges to shift service culture. In Victoria, peer support was reframed as a mechanism to drive human rights-based reform throughout the mental health system.

5. **The source and structure of funding matters**

Funding mechanisms influence longevity and legitimacy. Peer support roles have often been created through time-limited funding: COVID transformation budgets, innovation grants, or temporary government allocations. While these have enabled rapid experimentation, they leave roles vulnerable in times of austerity. Systems that embedded peer support into core budgets or repurposed unspent clinical funds were more likely to sustain roles.

Example: In Wales, peer roles were initially funded through transformation grants and COVID recovery funds but are now threatened by budget pressures. In contrast, parts of England and Victoria have reallocated unfilled clinical vacancies to fund peer positions long-term. In Ireland and Canada, roles tied to time-limited grant programmes have faced higher attrition and are now facing either an end of funding or restructure.

6. **Role clarity and recognition of peer support as a distinct discipline**

Formalising peer support as its own discipline through qualifications, job bands, or role frameworks helped protect its identity and quality. Without clear recognition, peer roles risked being subsumed into clinical models or losing their distinctiveness. Countries with nationally recognised peer qualifications or frameworks reported more successful integration and staff retention.

Example: Peer Support Canada national certification programme, Victoria's Consumer Discipline Framework and Certificate IV in Mental Health Peer Work, England's development of national capabilities through NHS England and Imroc collaborations.

7. **Peer work thrives in collective and culturally resonant models**

Peer support resonates most where it aligns with collective, community-based, or non-individualised models of wellbeing including in Indigenous communities, minority language regions, and cultures with strong relational traditions. In these contexts, peer support has acted as a culturally safe bridge into systems that are otherwise experienced as colonial, clinical, or exclusionary.

Example: Māori and Pasifika peer roles in Aotearoa New Zealand are framed as cultural roles, not clinical substitutes. In North Wales, Welsh-language peer support and recovery colleges are helping reconnect communities to mental health systems that previously excluded them.

8. **International exchange and collaboration catalyses local action**

Several countries drew explicitly on international models and expertise to legitimise their own work or fast-track development. Bringing in respected peer leaders from abroad, sharing frameworks, or referencing international evidence helped accelerate progress, build credibility,

shift mindsets, or influence funders especially when facing credibility barriers or internal resistance. International voices offered validation, fresh framing, and political leverage.

Example: Ireland invited international peer leaders from England and Aotearoa New Zealand to unlock support for peer support and support its early implementation; Wales drew on frameworks and insights from England's recovery college network; Victoria referenced Aotearoa New Zealand's peer-led crisis models in shaping future directions and they frequently draw on international relationships to shape practice and strategy.

9. Small systems can scale quickly but face unique risks

Smaller countries and regions were able to move more rapidly due to closer networks, fewer layers of bureaucracy, and relational leadership. However, they were also more dependent on individual champions and more vulnerable to political or staffing changes. Without structural embedding, progress remained fragile.

Example: Denmark, Wales and Aotearoa New Zealand both experienced rapid early scaling, but sustainability depended heavily on a small number of leaders and policy advocates. Implementation often varied dramatically across regions within these countries.

10. Peer support is often vulnerable, but it does not have to be

In nearly every country, peer support has grown in a context of fragility: financial precarity, role ambiguity, and political volatility. But this is not inevitable. Where peer support is institutionally embedded, where leaders are supported, and where policy frameworks align with lived experience values, peer support becomes a lasting, system-shifting force.

Example: The Alfred Hospital in Victoria grew its peer workforce from 5 to 70 roles with no external funding, demonstrating that values-based leadership and executive support can protect and grow peer roles even within clinical institutions.

11. Tokenism and over-professionalisation remain active risks

Even in countries with advanced peer support systems, concerns remain about co-option, dilution, or peer roles being absorbed into dominant clinical paradigms. Over-professionalisation, while often intended to strengthen legitimacy, can lead to loss of values, hierarchy, and exclusion of non-traditional candidates.

Example: Demark's peer support approach has grown mainly within clinical setting, with top down political leadership. England and Victoria have both noted tensions around peer roles becoming overly aligned with managerial or clinical structures, limiting autonomy and the power of lived experience and the potential for mental health service transformation.

12. Political will and executive sponsorship matter

Where peer support had high-level champions, either political leaders or senior clinical executives, implementation advanced more quickly and encountered fewer barriers. In contrast, systems without these champions often saw fragmented or stalled progress.

Example: Victoria benefitted from ministerial advocacy post-Royal Commission and executive leadership in major hospitals. Demark has benefited from the leadership of an ex-prime minister. In England, the absence of political involvement has meant change has been down to health trusts which has still resulted in extensive change but may not withstand government restructuring of health which is forthcoming.

Country Summaries

British Colombia, Canada

Given the size and diversity of Canada, this report draws on national developments in peer support while focusing specific examples from British Columbia and Ontario. These two provinces offer rich and instructive models, but the broader analysis reflects key national drivers, challenges, and innovations that have shaped the growth of peer support across the country.

This dual focus allows us to highlight both regional innovation and nationwide momentum. Importantly, this overview has been designed to support meaningful comparison with Scotland, helping to illustrate what can be achieved when recovery-oriented, peer-led, and co-produced approaches are supported at multiple system levels.

1. Key Messages

- **Standardisation and certification**: Canada has made significant strides in formalising peer support through national standards and certification processes. Peer Support Canada (PSC) has developed certification frameworks to validate lived experience and ensure quality support provision.
- **Recovery-oriented innovation**: Innovative peer-informed models in Canada have catalysed recovery-oriented shifts in both clinical and community services.
- **Grassroots origins**: The peer support movement began as a grassroots effort in response to gaps in traditional mental health services, evolving to now being embedded within mainstream systems such as hospitals.
- **Greater acceptance and demand**: Across regions, there has been greater acceptance of peer support, with more funding applications, grantors and health services including peer support as a service desirable/requirement, further increasing credibility.
- **Integration challenges**: Despite notable progress, there remains a lack of strategic oversight and understanding of peer support roles, particularly within clinical settings. This affects both service delivery and worker wellbeing. Many programmes continue to struggle with inconsistent implementation, unclear expectations, and informal management practices.
- **Need for career progression**: While peer support roles have grown, there is limited infrastructure supporting upward mobility and leadership development, meaning a lack of opportunity for professional growth beyond frontline roles.
- **Locally driven leadership matters**: In British Columbia, strong local leadership by people with lived experience has sustained and grown peer support, even in the absence of a coordinated national voice. Passionate coordinators and peer leaders have been central to maintaining momentum, building trust, and securing local buy-in. Significant attention has been paid to the workplace conditions required for peer support to thrive and deliver impact.

2. Context

Canada is a federation comprising regions with their own health system governance. This decentralised structure has fostered diverse approaches to mental health reform and created space for locally driven peer support models. In the absence of a cohesive national strategy or overarching governance, some provinces, such as British Columbia, have moved ahead independently to build the structures, support, and advocacy needed to embed peer support within mental health services. This localised approach has allowed for innovation and

responsiveness in places where peer support is valued and well-resourced. It has also resulted in a fragmented national landscape, where the pace and quality of peer support implementation varies widely. While local leadership has enabled innovation in some provinces like British Columbia, the lack of coordinated national guidance has left others without the infrastructure to scale or sustain peer support.

The establishment of the Mental Health Commission of Canada (MHCC) in 2007, following the 2006 Standing Senate Committee report, was a turning point for mental health reform. The MHCC's Changing Directions, Changing Lives (2012) national strategy emphasised recovery-oriented care including peer support as a key pillar (MHCC, 2012). As part of this work, MHCC established a national advisory committee on peer support and convened peer leaders from across Canada alongside international experts such as Mary O'Hagan and Robyn Priest. This led to the creation of the *Guidelines for the Practice and Training of Peer Support* and the *Making Peer Support Practical* report. When the advisory committee's work concluded, Peer Support Canada was formed to continue advancing the field and steward the certification process.

A key focus for some in Canada has been on certification to enhance the profession's credibility, trust, and legitimacy. While certification is not always mandatory, training is increasingly required. Affordability remains a consideration, as certification may be employer-funded or self-funded.

Peer support grew out of community-based advocacy, particularly among people who had experienced psychiatric hospitalisation or exclusion from services. These movements were instrumental in the early development of peer support roles and laid the groundwork for integration into clinical settings, including hospitals and Assertive Community Treatment (ACT) teams.

Today, efforts are underway to ensure common standards and language while respecting the diversity of peer support approaches across regions.

"I think there's an attitude that's changing among clinicians and among peer supporters about the ability to work together and feeling like they're valued inside the system."

Despite these advancements, peer support in Canada still lacks a unified language and standardised practice framework recognised across all service sectors.

"Right now, when we're talking about peer support, half of us are talking about different things that don't even look the same [...] there's no commonality in the language that applies to other kinds of people."

While the absence of a national voice for peer support has led to stagnation in some provinces, British Columbia continues to expand its peer support programmes. Peer leadership, strong local relationships, and the historical roots of the movement have helped it thrive independently of national structures.

Policy and Infrastructure Timeline

- **Pre 2006**: Grassroots and community led peer support programmes running in voluntary and paid capacity across the country.
- **2006**: Senate report on mental health, leads to the formation of the Mental Health Commission of Canada (MHCC).
- **2007**: Mental Health Commission of Canada established.

- **Early 2000s**: Veterans peer support and learning from the Georgia model in the U.S. helped catalyse national momentum in the mental health sector, influencing early thinking on training, competencies, and formal recognition of peer support.
- **2012**: *Changing Directions, Changing Lives* strategy launched by the Mental Health Commission of Canada, identifying peer support as a priority.
- **2013**: *Guidelines for the Practice and Training of Peer Support* released with peer support competencies developed by Peer Support Accreditation Canada (now Peer Support Canada).
- **2014**: Peer Support Canada formed as an independent body.
- **2017+:** Growth of peer roles in community mental health organisations and clinical teams (including Assertive Community Treatment (ACT) teams).
- **2020s**: Provincial innovations expand peer roles and community-led crisis response models emerge, such as CRCL (formerly PACT), offering peer-based, non-police alternatives to crisis care in British Columbia.

3. Enablers and Drivers for the Growth of Peer Support

Policy and Strategy

- The MHCC published *Guidelines for the Practice and Training of Peer Support* in 2013, which established principles such as hope, self-determination, and empathy as the foundation for peer support roles (MHCC, 2013) and have helped shape a national vision for peer support.
- Peer Support Canada (PSC), created out from the work of the MHCC, but independent, has developed national certification standards. Their *Certification Handbook* (2024) outlines core competencies and an assessment process for individuals and organisations to recognise competencies and strengthen practice integrity (Support House, 2024).
- In British Columbia, the establishment of a dedicated Ministry of Mental Health and Addictions in 2017 signalled a significant commitment to mental health reform. The province launched 'A Pathway to Hope', which explicitly supports peer training and development.
- British Columbia has also developed a robust, skills-based peer training model aligned with Peer Support Canada's knowledge matrix. The programme includes 96 hours of class-based training and a practicum/internship and is increasingly recognised as a regional standard for ensuring peer readiness and quality.
- Local peer leaders and coordinators maintain strong cross-programme communication, helping reinforce consistent practice standards, though uptake of the model varies across communities.
- The opioid crisis also accelerated the integration of peer support within substance use services, influencing wider adoption of peer support in mental health.

Community Initiatives

- The adoption of Assertive Community Treatment (ACT) in British Columbia has provided a strong model for embedding Peer Supporters into multidisciplinary teams, setting an example for the integration of peer support in clinical teams.

- In British Columbia, CRCL – Crisis Response, Community-Led (formerly known as PACT) has emerged as an innovative, non-police crisis response model. CRCL teams pair peer supporters with clinical professionals to provide trauma-informed, culturally relevant, and voluntary mental health crisis support. Now active in several communities including North Vancouver and Victoria, CRCL demonstrates how peer-led crisis intervention can be scaled as a community-centred alternative to traditional emergency response.
- Community-based organisations like the Canadian Mental Health Association (CMHA) have developed a variety of peer support programmes, empowering people to connect with peers and community supports. Increasingly, these organisations are recognising that the effectiveness of peer support depends not only on strong training, but on thoughtful recruitment, clear supervision, and the right workplace conditions to ensure safe, sustainable practice.
- Peer-run organisations have also played a key role in advocating for system-level changes and in designing culturally relevant supports, particularly in Indigenous and racialised communities.
- The launch of Peer Connect, a provincial peer network in British Columbia, has further strengthened collaboration and professional identity within the sector.
- Recovery Colleges across Canada, such as Recovery College YVR in British Columbia, developed by CMHA North and West Vancouver with Vancouver Coastal Health, have expanded access to low-barrier, co-produced learning environments that support wellness and recovery. These initiatives have opened up new peer support roles in community settings and strengthened the recognition of lived experience as a core asset in service delivery.

Cultural and Strategic Drivers

- There is growing openness among clinical leads to incorporate peer support, with a growing desire to learn how to best support Peer Supporters. Peer support is doing better in areas where direct exposure and collaboration with peer supporters have led to clinician mindset shifts. Initially, there may be resistance, but as clinicians see the impact of peer support, respect and recognition grow.
- The push for Integrated Youth Services within the province included Peer Support within the approach allowing space and time for the practice to establish province wide.
- The presence of lived experience at the leadership level remains limited. "*We need to provide them with opportunities to move beyond the front lines… allowing them to make change within the system,*" emphasising the imperative to create advancement opportunities.
- There remain challenges in providing supervision, support and workplace inclusion for Peer Supporters. "*There was this openness from the team leads to want to learn to do better for the peer support workers*."
- Peer support is increasingly recognised as a valid area for action-based research, contributing to both practice development and evidence-building.
- Peer support's growing legitimacy within some clinical teams in BC has been supported by clearer role definitions and strong training standards, helping reduce confusion and

enable collaboration. While experiences vary, integration into multidisciplinary teams, particularly through unionised roles, has started to build credibility, security, and mutual respect. Flexible contract roles continue to offer valued options for those seeking limited hours or entry pathways.

4. Summary of What Was Found

While there is already a robust evidence base highlighting the positive impact of peer support workers across diverse settings, the next step is the development of practical implementation plans and a cohesive, system-wide strategy to ensure their continued integration and growth. This includes intentional planning around infrastructure, supervision, and leadership pathways.

Peer support in Canada is characterised by:

- Strong foundations in values-based practice, backed by national standards and growing training infrastructure. This includes a formalised structure for training and certification, particularly through Peer Support Canada.
- Programmes that embed lived-experience leadership from day one consistently achieves stronger engagement, sustainability, and outcomes. Early co-design with lived-experience leaders proved critical to long-term programme fidelity.
- Widespread presence of Peer Supporters in community and some clinical environments, especially in progressive provinces.
- Recognition of the benefits of embedding peer support at all levels from direct support to leadership, although this is still something that requires more work and advocacy.
- Peer support is increasingly recognised, but organisational readiness remains uneven. Many services still lack clear structures for supervision, boundaries, and ongoing support, leading to variable integration and outcomes.
- As digital mental health solutions proliferate, there is increasing misuse of the term “peer support” to describe anonymous forums, delayed-response platforms, or chatbot-based interactions. This has led to calls for clear delineation between genuine peer support grounded in relationship and mutuality, and broader digital engagement tools.
- Tensions between grassroots origins and institutionalisation, including concerns about tokenism and lack of upward mobility.
- Increasing demand for peer support, seen in more service requests and inclusion in funding proposals, reflecting the growing credibility of the role.

There are pockets across the country where peer support is seen as creating more compassionate, human-centred care:

"I have psychiatrists who are actively seeking out peer support... because I see what positive impact it's had for my other patients."

"We will always have peer support workers doing frontline positions in our programme... they're really good at being empathetic and building connections."

Canada has demonstrated how peer support can thrive within a flexible, values-driven approach to mental health transformation. Initiatives that are grounded in lived experience and co-designed

with communities consistently show better outcomes and stronger alignment with recovery values.

More peer support workers on the frontline is not enough if the environment is not conducive to support their development. There should be more peer leadership opportunities and support for their wellbeing. This is increasingly being recognised across provinces, with calls for peer-led supervision, meaningful career pathways, and mental health supports tailored for peer workers.

As peer support grows in visibility and impact, there is momentum now toward:

- Expanding leadership opportunities for Peer Supporters and people with lived experience.
- Strengthening supervision, training, and governance.
- Fostering a common understanding of peer support across systems.
- Deepening action-based research on peer support practices.

5. Examples Peer Support Services in Canada

A. CMHA Thames Valley's Crisis Services (Ontario)

- Offers 24/7 support, including mobile crisis intervention and stabilisation, short-term residential services, and transitional supports.
- Integrates Peer Supporters into frontline roles where they build relationships of empathy and mutuality with clients during and after a crisis.
- Emphasises transition support after discharge to promote long-term recovery.

B. Foundry Integrated Youth Services (British Colombia)

- Offers youth-friendly, one-stop access to mental health, substance use, primary care, and social services.
- Integrates both Youth Peer Support and Family Peer Support as core parts of the care team.
- Peer workers provide non-clinical support, facilitate wellness groups, and assist with system navigation.
- Services are built on co-design and lived experience leadership.
- Recognised nationally; model is being expanded across Canada with federal support.

C. Toronto Community Crisis Service (TCCS) (Ontario)

- Launched in 2022 as Toronto's 'fourth emergency service'. A non-police response to mental health crises.
- Provides trauma-informed, rights-based crisis intervention 24/7.
- A peer-inclusive alternative to police-led crisis response.
- Teams include peer support workers and mental health professionals, with 78% of calls resolved without police involvement in first year.
- TCCS is city-funded and rooted in community partnerships, including organisations serving racialised and marginalised communities.

D. CRCL: Crisis Response, Community-Led (British Columbia)

- Community-led crisis response service offering non-police, trauma-informed support through peer and clinical teams.
- Provides mobile response for people aged 13+ in mental health distress, aiming to de-escalate and build trust.

- Piloted in BC communities like North Vancouver and Victoria, reflecting a shift toward safer, peer-based crisis alternatives.
- Reflects a commitment to de-escalation, safety, and cultural relevance.

E. **Support House's Peer Support Residency Model (Ontario)**

- Offers embedded peer support within transitional housing programmes.
- Uses trauma-informed principles and values peer leadership in governance and programme design.

Denmark

1. Key Messages

- **Regionally led, nationally supported growth**: Peer support in Denmark has developed primarily through region-led initiatives, especially within hospital-based mental health services. While not formally mandated in national strategy, it is aligned with recovery principles and politically supported.
- **Strong political advocacy and partnerships**: Influential figures, such as former Prime Minister Poul Nyrup Rasmussen, have played a critical role in mainstreaming mental health reform, with peer support positioned as central to recovery-oriented practice.
- **Clinical integration as the dominant model**: Peer support in Denmark has been primarily embedded within clinical settings, especially psychiatric wards and outpatient services, with more limited presence in community-based or municipality-led services.
- **Structured peer training and coordination**: Comprehensive, regionally supported training programmes and Peer Coordinators ensure consistent role clarity and support, although supervision remains uneven and self-organised in places.
- **Gradual scaling with political and organisational backing**: Peer support has expanded steadily over the past decade, with some regions showing substantial growth in workforce numbers, role legitimacy, and influence on service culture. This has been supported by influential advocates, regional leadership, and increased role legitimacy.
- **Emerging peer leadership and career pathways**: While peer roles are well embedded, nationally standardised career trajectories and formal peer-led supervision structures are still under development.

2. Context

Peer support in Denmark has evolved over the past ten years within a highly structured and regionally governed health system. The country is divided into five regions and 98 municipalities, with mental health services primarily falling under the remit of regional authorities. Unlike other countries where peer support has often grown from grassroots movements, Denmark's development has been more top-down, with strong clinical, political, and academic backing.

A national shift towards recovery-oriented mental health care has underpinned the growth of peer support, especially following a 10-year national mental health plan to reform psychiatry. Peer support has been positioned as a key mechanism to embed recovery values, support empowerment, and transform service culture.

The partnership Peer Partnerskabet**,** formed by Det Sociale Netværk and SIND**,** has provided critical leadership. Det Sociale Netværk, founded in 2009 by former Prime Minister Poul Nyrup Rasmussen following personal advocacy linked to his daughter's experiences with mental illness, brings strong political connections and has been influential in driving mental health reforms in Denmark, including the promotion of peer support. Their combined advocacy, along with Rasmussen's personal and public profile, has elevated peer support to a politically visible and nationally supported priority. The organisation plays a central role in policy advocacy, mental

health education, and raising the profile of peer support through national psychiatry summits and other key platforms.

"When you have a former Prime Minister saying this matters, that recovery, lived experience, and peer support should be part of the future, it gives us permission to do things differently."

Denmark is part of the Nordplus-funded Baltic and Nordic Partnership for Peer Support Workers, which promotes knowledge exchange between Nordic countries, enhancing Denmark's understanding and implementation of peer support. This international learning has influenced training and practice models within Denmark, aligning them with broader European standards.

While most peer workers are employed in hospital settings (managed by regions), there is an emerging ambition to expand peer roles into municipality-led services (social psychiatry, community-based care), although progress here is slower. Peer support is valued for its role in promoting hope**,** self-determination, and recovery, not just for service users but also as a positive influence on professionals and families.

The pace of change has been steady, with regionally led pilots growing into more formalised roles. The Copenhagen region, for example, has gone from 6 peer workers in 2013 to around 90 by 2022, now covering almost every ward and Flexible Assertive Community Treatment (F-ACT) team.

Peer leadership is emerging, especially through networks like Peer Partnerskabet, which advocates for expanding peer roles beyond clinical settings into municipalities. While career pathways are still developing, some experienced peer workers have progressed into supervisory or training positions, signalling early steps toward professionalisation. Few peer-led services exist at present, but there is growing interest in creating peer-driven initiatives in community psychiatry, including supported housing and youth services.

While most peer support remains within clinical frameworks, some self-organised peer networks provide peer supervision and informal support.

"Peer support in Denmark has grown inside the walls of hospitals. That's where we've had the support, the leadership, and the budgets. We're still working to bring it out into the community."

Policy and Infrastructure Timeline

- **2007**: Major health reform decentralises responsibility, granting municipalities a larger role in health promotion and mental health support.
- **2009**: Det Sociale Netværk established, with strong political support helping shape national discourse on mental health reform and recovery-oriented practice.
- **2010**: Introduction of outpatient commitment legislation marks a shift toward community-based mental health care.
- **2010s**: Growing national focus on psychiatric reform, recovery, and user involvement. Mental health becomes increasingly visible in public policy and media debates.
- **2012**: Danish Health Authority issues updated prevention packages for municipalities, including evidence-based guidance for mental health promotion and psychosocial support.
- **2013**: Pilot peer support project in Copenhagen region; first part-time Peer Coordinator appointed in psychiatry.
- **2015**: Expansion to 25 peer workers across 10 hospitals in the Copenhagen region.
- **2018**: Peer Partnerskabet established as a collaboration between Det Sociale Netværk and SIND scaling up peer support and formalising partnerships with regional health services.

- **2019**: The Psychiatry Competence Centre for Rehabilitation and Recovery develops peer support training in Copenhagen; government commits DKK 600 million annually to improve mental health services.
- **2021**: 80+ peer workers are embedded in nearly all psychiatric wards and F-ACT teams in the Copenhagen Region, demonstrating system-level uptake.
- **2022**: Over 90 peer workers are active in the Copenhagen region; greater attention is paid to expanding peer roles into municipalities and community services.

3. Key Enablers and Drivers for the Growth of Peer Support

Government Commitment and Strategic Reform

- The growth of peer support in Denmark has been driven by high-level advocacy and strategic influence from Det Sociale Netværk and Peer Partnerskabet, which have played a pivotal role in advancing system change and embedding recovery-oriented practices within regional healthcare. Their work has been strengthened by the leadership of founder and former Prime Minister, whose personal connection to mental health issues lent credibility and visibility to the cause, helping make peer support a politically supported priority.
- Although peer support is not explicitly mandated by the 10-Year Plan for Psychiatric Care, the plan's strong focus on user involvement and recovery has provided a supportive policy environment for the introduction and expansion of peer roles.
- Peer Partnerskabet, as a collaboration between Det Sociale Netværk and SIND, works closely with regional authorities to advance peer roles as a distinct and valued part of mental health services.
- The City of Copenhagen's Action Plan for Better Mental Health (2019–2026) also supports user involvement and innovative mental health practices, indirectly contributing to a climate in which peer support is valued.

Clinical Leadership and Organisational Support

- Peer support has largely developed within clinically led environments, particularly in regional psychiatric hospitals. Clinical leaders, such as supportive psychiatrists and nurse managers, have been essential in creating space for peer roles to grow.
- Each of Denmark's five regions has taken responsibility for implementing peer support within its hospital system, allowing for variation in models but fostering strong local ownership.
- Peer Coordinators in each region play a crucial role in recruiting, inducting, and supporting peer workers, though supervision structures vary across regions.
- Managerial engagement has included preparing teams for peer integration, collaborating with Peer Coordinators, and clarifying the distinct role of peer workers in multidisciplinary settings.

Training and Professional Development

- The Copenhagen Psychiatry Competence Centre for Rehabilitation and Recovery developed a 16-day peer training course, focused on recovery, communication, group facilitation, and interdisciplinary working.
- Training is practice-oriented, with a mix of in-role reflection and classroom learning, tailored to the needs of part-time peer workers.
- Peer training is also accessible across regions, supporting some standardisation in role development.
- Although there is no national certification, training is widely respected across regions, with some regional variation in how it is implemented.

Recovery-Oriented Service Reform

- Peer support is understood as a tool for shifting service culture towards recovery, empowering service users, and fostering hope.
- Key aims include helping service users regain control, contribute to their treatment planning, and bridge clinical services with community life.

International Collaboration

- Denmark's peer support development has also benefited from international collaboration, particularly through the Nordplus-funded Baltic and Nordic Partnership for Peer Support Workers, which fosters shared learning across Denmark, Sweden, Norway, Finland, and Estonia. This collaboration supports the exchange of training models, research, and policy insights that have enriched Denmark's peer workforce development.
- Denmark has drawn from UK-based recovery frameworks, particularly the CHIME model (Connectedness, Hope, Identity, Meaning, Empowerment) and organisational recovery strategies from Imroc (Implementing Recovery through Organisational Change), to inform peer training and recovery-oriented service design. These influences are visible in the design of peer training programmes, especially at the Copenhagen Psychiatry Competence Centre for Rehabilitation and Recovery.
- Early training structures took inspiration from SAMHSA's guidelines (Substance Abuse and Mental Health Services Administration) but have since been localised to suit Denmark's more clinically embedded peer support system.

4. Summary of What Was Found

Peer support in Denmark has progressed steadily over the last decade, moving from pilot projects to broader regional implementation, particularly within hospital settings. The development has been driven more by **clinically led initiatives**, supported by politically connected advocacy organisations, rather than grassroots peer-led movements. Peer workers are primarily located within psychiatric hospitals and outpatient settings, playing a key role in service-user support, group facilitation, and fostering recovery-oriented environments.

While community-based peer support remains less developed, partnerships like those led by Peer Partnerskabet and international collaborations through Nordplus have expanded the scope of peer work beyond clinical settings. The presence of strong policy advocates, such as Det Sociale

Netværk, has ensured peer support remains on the national agenda, despite its limited mention in formal strategic documents.

While regionally adapted models have enabled flexibility, they have also led to some variation in training, supervision, and role expectations. Peer Coordinators provide a vital link between peer workers and service managers, ensuring recruitment, induction, and fidelity to role values. However, some challenges remain in ensuring consistent peer supervision and addressing role clarity, especially in settings where peer workers are isolated within large teams.

There is a strong foundation of peer training, with efforts underway to expand peer roles into municipality-led services. The experience of regions like Copenhagen and Zealand demonstrates that peer roles can thrive within clinical settings when supported by education, managerial engagement, and policy alignment.

Denmark's peer support movement benefits from national-level partnerships, but progress relies heavily on regional action. While community-led peer support remains limited, there is growing recognition of the value of peer support across both clinical and social psychiatry.

5. Examples Peer Support Services in Denmark

A. Copenhagen Region Peer Support Programme:

- Started in 2013 with 6 peer workers, now expanded to 90+ across almost all psychiatric wards and F-ACT teams.
- Peer roles in youth psychiatry, eating disorders, substance misuse, and supported housing.
- Strong Peer Coordinator team and structured induction/training model.

B. Zealand Region Peer Integration:

- 30 peer workers across 25 units, supported by one Peer Coordinator.
- Monthly peer meetings for reflection and mutual support.
- Recent evaluation shows high staff appreciation of peer workers, though role clarity challenges persist.

C. Peer Partnerskabet:

- National partnership advancing knowledge, policy influence, and peer practice development.
- Engaged in Nordplus collaborations, advancing peer learning across Nordic countries.

D. The Danish Association for Depression – Peer-Led Community Activities

- A nationwide organisation supporting individuals with depression or bipolar disorder and their families, the association offers various peer-led initiatives, including self-help groups, a social café in Copenhagen, outdoor events, courses, a summer college, and virtual cafés.
- These activities aim to foster community, reduce stigma, and promote recovery

England

1. Key Messages

- **Named Recovery/Peer Support leaders with respect from across different sectors are critical**: England's peer support movement has been significantly influenced by key leaders operating across health, academia, and the third sector. Their cross-sector collaboration and reputation has been pivotal in driving change and establishing international reputations.
- **National policy frameworks**, including *No Health Without Mental Health* and the NHS *Long Term Plan*, have created space and funding for the development of peer roles.
- **Peer support implementation has been NHS driven**: The commissioning space created by NHS England facilitated the management and integration of peer support within services.
- Key organisations, notably Imroc (Implementing Recovery through Organisational Change), have played a catalytic role in **embedding recovery principles and co-production in NHS Trusts**.
- **Limited political involvement set the conditions**: Once conducive conditions for change were established, political figures played a minimal role in the progression of peer support initiatives.
- **Workforce planning**: Strategic workforce planning has been central to the growth of peer support, with emerging training and career development pathways. However, earlier implementation of these pathways might have accelerated progress.
- **Involvement, co-development and leadership of lived experience**: Involving peer and lived experience expertise in decision-making processes is crucial, as opposed to top-down decisions made without such insights.
- **Peer support as a vehicle for culture change, not an end in itself**: Peer roles should not be viewed solely through workforce targets. Their real value lies in supporting a broader transformation of service culture, shifting the focus from symptoms and professional control toward relationships, empowerment, and whole-person care

"Think about firstly involving or using peer expertise and peer leadership in the decision making because there's loads of examples where decisions have been made about peer support roles by somebody who's like a programme manager down here... So the peer leadership bit is so important to have in there."

2. Context

The development of peer support in England has been shaped by a unique mix of health system features, policy initiatives, social movements, and funding pressures. England's National Health Service (NHS), one of the largest publicly funded healthcare systems globally, provides mental

health services through a network of over 50 NHS mental health Trusts. While national policy and strategy are set centrally (by the Department of Health and NHS England), implementation is largely devolved to local Trusts, each managing its own budgets, priorities, and workforce. This structural feature has been both a strength, enabling local innovation, and a challenge, resulting in wide variation in peer support delivery.

Peer support's rise in England can be traced back to broader recovery-focused reforms in the 2000s. Early policy documents, such as *Our Choices in Mental Health* (2007), introduced concepts of personalised care, empowerment, and self-management setting the stage for a more recovery-oriented approach. These ideas were given stronger weight in the 2011 cross-government strategy *No Health Without Mental Health*, which formally positioned recovery as a guiding principle and called for stronger involvement of people with lived experience.

The momentum continued with the *Five Year Forward View for Mental Health* (2016), which placed recovery and peer roles at the heart of NHS transformation plans. The most significant milestone arrived with the *NHS Long Term Plan* (2019) which set an ambitious national target of recruiting 5,000 peer support workers by 2024, a critical milestone in scaling peer work from niche small scale initiatives to national significance and mainstream integration. Alongside these national policies, Health Education England's (HEE) *Competence Framework for Mental Health Peer Support Workers* (2020) provided a critical tool for formalising the skills, values, and capabilities expected of peer support workers.

However, implementation across England has been uneven. Historically, peer support grew from the grassroots, often led by survivor networks, user-led organisations and third sector initiatives. Over time, NHS Trusts began employing peer support workers in a variety of roles, initially on an informal basis, later through dedicated recruitment. However, the scale-up has faced challenges. England lacks a centralised system to standardise peer worker roles, leaving each Trust to determine its level of investment, approach to training, supervision arrangements, and career pathways. As a result, peer support workers typically enter the NHS at band 3 or 4 (on NHS pay scales), often without clear routes to leadership or specialisation.

Beyond structural inconsistencies, broader system challenges have shaped the peer support landscape. Austerity measures introduced after 2010 led to deep cuts across public services, including mental health and the third sector, spaces where peer support was pioneered. Many survivor-led organisations were weakened or disappeared:

"Scattered diamonds instead of a beautiful piece of jewellery; brilliant individuals without cohesive collective power."

Trusts under financial pressure often used money saved from vacant posts to support peer roles. Yet, even in leading sites such as Nottinghamshire Healthcare NHS Foundation Trust, peer roles remain a small fraction of the total workforce (~150 peer workers in a Trust of ~12,000 staff), highlighting the marginal scale of peer support within the NHS.

Culturally, while the language of co-production, lived experience, and recovery is increasingly embedded in policy documents and organisational strategies, the reality of power-sharing between professionals and peer workers remains inconsistent on the ground. The absence of strong national mechanisms to hold Trusts accountable for achieving peer support targets has further limited progress. Without robust government oversight, peer support risks remaining underdeveloped, unevenly distributed, and vulnerable to being deprioritised during financial pressures.

England's peer support system has been built through a combination of grassroots energy, national ambition, and local adaptation, but faces persistent challenges in achieving consistency, sustainability, and meaningful integration across the country.

Policy and infrastructure timeline

- **2001–2004:** Early recovery-focused influence. The NHS begins exploring recovery-focused ideas influenced by international models (e.g., from Aotearoa New Zealand and the US). Some early peer roles emerge informally, especially in third-sector organisations and grassroots survivor networks.
- **2007:** "Our Choices in Mental Health" (Department of Health): A major policy paper promoting personalised care, self-management, and recovery approaches lays groundwork for later peer initiatives.
- **2009–2011**: NHS Recovery-Oriented Practice Pilots within NHS Trusts often supported by third sector partnerships. Peer support roles emerge in a handful of mental health Trusts, typically without national guidance.
- **2011**: Launch of the "No Health Without Mental Health" strategy, emphasising recovery-oriented approaches. This marks a turning point in policy, embedding recovery principles into England's national mental health strategy. It highlights the role of peer support and sets the stage for formal programmes.
- **2011-2014:** Imroc (Implementing Recovery through Organisational Change) programme funded by the Department of Health to work with over 30 mental health Trusts on embedding recovery and lived experience into services.
- **2014-2016**: The growth of Recovery Colleges becomes a key delivery mechanism for peer support. NHS Trusts develop local peer support worker posts, but progress is uneven and largely dependent on local leadership.
- **2016**: Publication of the "Five Year Forward View for Mental Health" (NHS England) establishes a national ambition for mental health transformation, explicitly referencing the value of peer support and encourages Trusts to develop and embed peer roles.
- **2019**: Introduction of the NHS Long Term Plan, setting a national target of 5,000 peer support workers across England by 2024. Embeds peer support into NHS workforce planning and highlights its role in improving access, experience, and outcomes.
- **2020-Present**: HEE publishes *Competence Framework;* NHS England releases *Peer Support: Working with People and Communities* and *Supported Self-Management: Peer Support – A Guide for NHS Commissioners*. Merger of Health Education England into NHS England, aiming to streamline workforce planning and training including the peer support workforce. Ongoing initiatives to create clearer career pathways, supervision models, and leadership roles for peer workers and local workforce plans begin to incorporate peer support workers.

3. Enablers and Drivers for the Growth of Peer Support

Leadership and champions:

- Influential figures, both with lived experience and as system allies, have driven cultural and organisational change. Executive-level champions, such as Chief Medical Officers who embed peer insight into service design and decision-making, play a vital role in

legitimising peer support. By contrast, token support from leaders driven by appearances or funding aims can limit meaningful progress.

- Peer support growth has been led by individuals who can 'live in both worlds'; those with lived experience who also have credibility with policymakers, researchers, and clinicians. This bridging capacity has been essential in building trust and sustaining momentum across sectors.
- NHS England and partner organisations like Imroc have championed peer support, advocating and facilitating its integration into services.
- Developing peer leadership and infrastructure before scaling recruitment can lay stronger foundations for peer support. Most Trusts have followed a conventional path: recruiting peer workers first, then developing supervision and career pathways. However, some evidence suggests that building leadership capacity and infrastructure early (as demonstrated by the Recovery Programme at TEWV NHS Foundation Trust) can result in more sustainable, values-driven, and well-integrated peer teams.
- Lived experience leaders have played critical roles at local and national levels, opening space for peer voices in governance and service delivery.
- Mentorship and "safe advocacy" have been crucial, allowing leaders to balance truth-telling with political astuteness when driving system change.

Policy and Strategic Drivers:

- National strategies such as *No Health Without Mental Health* (2011), *Five Year Forward View for Mental Health* (2016), and the NHS *Long Term Plan* (2019) explicitly endorsed peer support as part of recovery-focused services.
- The NHS Long Term Plan's target of 5,000 peer support workers sent a strong operational signal to Trusts to prioritise peer recruitment and integration.
- Imroc (Implementing Recovery through Organisational Change) has been pivotal in embedding recovery and co-production principles across NHS Trusts, offering training, tools, and consultancy.
- National guidance, including Health Education England's *Competence Framework* and NHS England implementation guides, has supported Trusts with practical frameworks and standards. Despite this, there remains no link between national ambitions and local workforce plans, creating a policy-practice gap and inconsistent implementation.

Workforce and System Transformation

- Peer support is increasingly recognised as part of NHS workforce transformation alongside clinical and managerial professions.
- Investments have been made in supervision structures, competency development, and formal recruitment processes for peer support workers.
- Maintaining the distinctiveness of peer support is essential. Peer workers bring relational, experiential insight, not therapy or professionalised expertise. As roles become more

formalised, there is a risk of 'therapising' peer work, undermining its core values of mutuality and shared humanity. Clear role definitions and training are vital to retain peer integrity.

- Training pathways, such as the Certificate IV in Mental Health Peer Work, have expanded in partnership with education providers and voluntary sector organisations.
- A small but growing number of NHS Trusts are developing clear career progression routes and leadership opportunities for peer workers with positions reaching as high as Band 8c, such as *Head of Lived Experience* and one position at Band 9 as *Director of Lived Experience*. Other common progression roles include *Peer Support Team Lead* (Band 6), *Lived Experience Practice Lead* (Band 7), and *Head of Peer Support or Lived Experience* (Band 8a-8b), depending on the Trust.
- National peer support targets, such as the 5,000 peer workers goal, have created visibility but risk becoming symbolic if not matched by genuine structural and cultural change. Leaders have noted that in large Trusts, peer roles still represent a very small proportion of the workforce, raising questions about scale, integration, and equity.
- Much of the workforce growth in regions like Sussex was enabled by repurposing funding from long-standing clinical vacancies that could not be filled. This allowed teams to embed peer roles in services like urgent care and forensics, despite no dedicated peer support funding. Local leadership used transformation programme bids strategically to resource new roles.

Co-Production and Cultural Change:

- There has been a cultural shift toward co-production and shared decision-making in service design, quality improvement, and governance which has been a significant driver for change.
- Service users and carers are increasingly involved in shaping policies and service models, though the extent of meaningful power-sharing varies across regions.
- Peer input has become more visible in NHS policy conversations, organisational development, and recovery-focused transformation projects. For example, in TEWV NHS Trust, co-production is included training clinical teams in recovery values before deploying peer workers, ensuring readiness of teams, reducing role confusion, and supporting long-term culture change.

- Paid peer roles have helped move services away from a tokenistic or "involvement culture," signalling that lived experience is valued as expertise. This shift has contributed to more consistent integration of peer workers into multidisciplinary teams and stronger recognition of their professional contribution.
- Where peers are employed in senior roles, they are influencing not just individual care but also organisational strategy, through involvement in recruitment, service design, and governance structures. In these settings, peer leaders help "change the questions being asked" and bring recovery values into the heart of service development.

- However, some professional groups, notably nursing, continue to present barriers, and in some settings, peer roles remain excluded from care coordination and other clinical responsibilities.
- Regional peer lead networks, such as the Southeast Peer Leads group, have emerged organically, enabling collective problem-solving and sharing of good practice. These peer-led infrastructures are laying foundations for a national peer support association, enhancing collective power and advocacy.

Community and Third Sector Innovation

- Voluntary organisations, including Mind, Rethink Mental Illness, Together, and Hearing Voices Network, have long pioneered peer-led services.
- These organisations have introduced innovative models such as crisis cafes, peer mentoring, peer-led helplines, and online communities.
- The third sector has acted as both an incubator for peer work and a critical advocate for embedding lived experience across the mental health system.
- Recovery Colleges are increasingly evolving beyond NHS settings into broader community learning partnerships. Many now operate from libraries, football clubs, and local hubs, co-producing courses with community groups and funded by colleges or primary care networks. This shift supports wider community integration and reflects a trend toward peer-led, non-medicalised learning environments.
- Austerity, however, has weakened this sector's capacity to hold government and statutory services accountable, reducing independent pressure for system-wide reform.

"Peer support is like a tiny ice cube dropped into a giant bucket of water: it's there, and it matters, but it's hard to track its impact when the whole system is under stress."

4. Summary of What Was Found

England's peer support journey reflects both impressive progress and persistent challenges in embedding lived experience roles within a large and decentralised healthcare system.

Nationally, England is regarded as an early leader in recovery-oriented mental health practice. Major strategies, including No Health Without Mental Health, the Five Year Forward View for Mental Health, and the NHS Long Term Plan, have created a supportive policy environment. Programmes like Imroc have played an influential role in promoting recovery, co-production, and peer support across NHS Trusts, and their impact has been recognised internationally.

At the local level, implementation has been uneven. While some NHS Trusts (such as Nottinghamshire Healthcare NHS Foundation, Central and North West London (CNWL), and Mersey Care NHS Foundation), have developed substantial peer support workforces, established clear career pathways, and introduced innovative supervision models, others have limited or symbolic roles. For example, even where Trusts have long employed peer support workers, some staff report no formal training or role preparation, leading to confusion and stress for new peer

workers. The decentralised nature of the NHS, which allows local Trusts to determine their own strategies, has led to wide variation in the scale, quality, and sustainability of peer support across England.

The peer support workforce itself has emerged from a blend of grassroots initiatives and top-down policy support. Early growth was driven by survivor-led organisations, third-sector providers, and mutual aid groups, long before formal peer roles were created within the NHS. Over time, peer roles have become more professionalised within NHS settings, supported by the development of national competency frameworks and increasing investment in training and supervision.

Forensic mental health settings, while highly restrictive, have been sites of strong peer support integration. Long stays and staff burnout can make peer roles especially valued by both service users and professionals. However, these successes are often dependent on local champions, and lack of formal peer training in early implementations created risks around boundaries and role clarity.

Despite this progress, several ongoing challenges shape the current landscape. National policies have generated momentum but have not guaranteed local change. Leadership from people with lived experience, supported by clinical allies, has been a crucial driver of progress. Workforce development, including robust training, peer-specific supervision, and clear career development pathways has been central to ensuring peer roles move beyond symbolic or isolated positions.

Efforts to introduce peer roles without preparing services or ensuring adequate support structures have often led to role drift, isolation, or failure. A strong message from local leaders is to avoid placing a single peer into a service without sufficient peer support, supervision, or readiness groundwork, without it, it can be a recipe for disaster.

Peer leads are often required to function not only as practitioners but also as de facto change managers, service designers, and educators, often with little formal authority. The role's complexity and visibility places disproportionate expectations on individuals, raising questions about preparation and support for peer leadership.

External pressures, particularly austerity, have impacted both the statutory and voluntary sectors. Cuts to mental health and community services have reduced the capacity of independent, user-led organisations, which have historically been important innovators and advocates for peer support. Within the NHS, peer roles are sometimes at risk of being marginalised or deprioritised, particularly in financially constrained settings where they may be seen as non-core additions to clinical services.

Key lessons include:

- Leadership at all levels is critical. Progress depends on the combined efforts of national champions, local leaders, and lived experience advocates. Without this, peer support struggles to gain meaningful traction.
- Workforce infrastructure matters. Robust training, supervision, career pathways, and peer-specific leadership roles are essential to move peer work beyond tokenistic or symbolic positions.
- Co-production must go beyond rhetoric, embedding lived experience meaningfully in decision-making, design, and delivery requires genuine power-sharing, not just policy references.

- Cultural change takes time and investment. Embedding peer roles is not just a technical change but a cultural one. Shifting clinical and managerial attitudes to fully value lived experience is key to sustainability.
- Protecting community-based and user-led initiatives is essential. Years of austerity have eroded the independent peer movement, weakening survivor-led organisations and the voluntary sector. Protecting and rebuilding these spaces is as important as strengthening NHS-based peer roles.
- Change often starts with doing, not just policy. Imroc's approach has been to work alongside services to try things out, support local adaptation, and build trust through real-world experience. Rather than waiting for policy to lead, they have helped show what is possible by doing the work first, then sharing what they have learned. This grounded, relationship-based approach has been central to their influence.
- Treating peer support as a practice not just a role builds credibility and system influence. TEWV's experience shows that peer support can thrive when it is grounded in shared values, collective leadership, and intentional relationship-building. By focusing on peer support as a distinctive practice, with its own leadership model and infrastructure, they helped establish peer roles as credible, embedded, and valued across clinical teams.

Overall, England's experience demonstrates the importance of combining national policy, strong leadership, workforce infrastructure, and cultural change to embed peer support meaningfully and sustainably within the mental health system. While challenges remain, England continues to offer valuable lessons for other countries seeking to expand and integrate peer support across clinical and community settings.

5. Examples Peer Support Services in England

A. The Maytree Respite Centre (London)

- Maytree offers a unique, non-medical, peer-led residential respite for people in suicidal crisis.
- It is often cited as one of the few genuinely peer-led crisis alternatives in the UK.
- The team includes people with lived experience, and the organisational ethos is deeply grounded in mutuality, compassion, and peer principles.

B. Leeds Survivor-Led Crisis Service (Leeds)

- Historically operated as a survivor-led service offering out-of-hours support, helplines, and safe spaces, though its model has evolved in recent years.
- These services prioritise non-medical, peer-run environments where people can find safety and understanding in times of distress.

C. Likewise (London)

- A social care and mental health organisation with a highly relational, community-based approach, shaped by co-production and strong lived experience leadership.
- Many of its services including peer mentoring, social groups, and befriending are co-designed and delivered by people with lived experience.
- The organisation explicitly prioritises relational support, mutuality, and reducing hierarchy between staff and community members.

D. **Tyne, Esk and Wear Valley NHS Foundation Trust — A Complete Peer Workforce Infrastructure**

- A workforce of 50 peer supporters Peer Support positions from band 3 to Band 8c.
- A strategic target to have a workforce of more than 100 peer support positions within three years.
- A head of Peer Support with the lived experience, training and practice skill required for the role.
- Two director roles responsible for ensuring that co-production, lived experience leadership, and recovery-oriented approaches are embedded across the trust.
- A Peer Support management team that provides peer support practice leadership across the trust through the use of a shared Peer Support Leadership reflection and practice tool.
- A 71% retention rate of peer support staff at three years in post, far surpassing comparable programmes.

E. **NHS Midlands — Regional Director of Lived Experience**

- NHS Midlands became the first NHS England regional team to appoint a Director of Lived Experience at executive level, signalling a major shift in embedding lived experience leadership across system design, governance, and workforce transformation.
- This director role is responsible for ensuring that co-production, lived experience leadership, and recovery-oriented approaches are embedded across NHS trusts, integrated care systems, and mental health services in the Midlands.
- This move has positioned the Midlands as a national pioneer in elevating lived experience beyond frontline peer roles into senior system leadership influencing commissioning, strategy, and organisational culture at scale.

F. **Nottinghamshire Healthcare NHS Foundation Trust**

- Nottinghamshire Healthcare is widely regarded as a national leader in embedding peer support.
- With approximately 150 peer support workers across crisis, forensic, community, and rehabilitation services, the trust has developed robust supervision structures, peer-specific leadership roles, and a clear career pathway.
- It was one of the first trusts to formally partner with Imroc, helping pioneer recovery-oriented practice across large-scale NHS settings.

Aotearoa New Zealand

1. Key Messages

- **Diverse peer leadership across sectors**: Aotearoa New Zealand demonstrates a wide and growing presence of peer support and lived experience leadership not only in community and health services but also in government agencies, with roles influencing policy, training, service commissioning, and system transformation.
- **Decolonising and culturally grounded practices**: Māori peer services emphasise collective recovery (whānau-centred [family-centred]) rather than individual approaches and often operate outside Western peer language or models. Concepts such as *Tuakana-Teina* [older sibling-younger sibling] and *Te Whare Tapa Whā* [the four cornerstones of Māori health – family, physical, mental, spiritual] influence relational practice.
- **Stratified peer roles**: Aotearoa New Zealand recognises a nuanced Consumer, Peer Support, and Lived Experience (CPSLE) workforce. Roles include direct peer support, individual and *whānau* [family] advocacy, systemic advocacy, and system support positions embedded in service design and policy environments.
- **Government commitment and challenges**: National frameworks such as *Kia Manawanui Aotearoa* [Long-Term Pathway to Mental Wellbeing in New Zealand] and *Oranga Hinengaro Services* [Mental Wellbeing] *and Systems Framework* include lived experience-led transformation, but implementation varies. Trust in government remains low among Māori due to historical and intergenerational trauma.
- **Innovation and local leadership**: Services like *Tupu Ake* [To Grow Upwards], Aotearoa New Zealand's first peer-led alternative to acute care, reflect global leadership in peer innovation developed despite early clinical resistance.
- **Workforce growth and infrastructure**: National competency frameworks (e.g. CPSLE), training opportunities, and strategic funding have helped normalise peer roles across service types, including in Emergency Department settings, addictions, and youth. Use of unspent clinical FTE budgets to fund peer roles helped trial new models of inclusion in multidisciplinary teams.
- **Insider-government roles are valuable but challenging**: Peer leaders in government roles influence legislation and system transformation directly but face dual-accountability challenges. Their presence helps amplify community insight, inform investment, and navigate complexity.

2. Context

The development of peer support in Aotearoa New Zealand has been shaped by decades of advocacy, particularly from lived experience leaders and Māori communities demanding to be heard, valued, and respected. The 2017 Labour government responded to public demand with a national inquiry into mental health and addiction (*He Ara Oranga* [Pathways to Wellness]), which recommended privileging lived experience voices and those of Māori as central to mental health transformation. This inquiry led directly to the formation of the Mental Health and Wellbeing Commission (MHWC), a new entity tasked with monitoring and implementing recommendations.

Aotearoa New Zealand's peer support movement is shaped by its bicultural foundation under Te Tiriti o Waitangi (The Treaty of Waitangi) and the centrality of Māori and Pacific worldviews, which emphasise collective recovery, familial relationships (whānau), and holistic wellbeing. This has driven advocacy for community-led practice and culturally grounded models, particularly for communities who are seldom heard within dominant systems.

The existence of a national commission dedicated to mental health and wellbeing, alongside the formal inclusion of lived experience roles in government, reflects how far Aotearoa New Zealand has progressed compared to many countries where peer leadership remains peripheral or unsupported. These developments signal a significant achievement for the peer movement and have created new pathways for influence. However, although the Mental Health and Wellbeing Commission plays a vital oversight role, its lack of enforcement power limits its ability to drive meaningful change. Its recommendations carry advocacy weight but rely on voluntary action and strong relationships with government agencies. Without a dedicated, independent organisation to represent and unify peer support and *tangata whai ora* [people seeking wellness] voices nationally, there is a significant gap in the infrastructure needed to coordinate advocacy, protect peer identity, and influence policy from a community base. This absence means peer leadership often operates without the structural backing needed to sustain momentum or hold systems to account.

Infrastructure has expanded steadily since the 2020 Mental Health and Wellbeing Act and the *Pae Ora [*Healthy Futures*]* Act, which introduced a Code of Expectations mandating consumer and *whānau* [family] engagement across the health system. Lived experience roles remain within the Ministry of Health, ensuring insight reaches directly into strategic design, policy, and legislative processes, with relatively few barriers between peer knowledge and ministerial influence.

System restructuring consolidated 20 District Health Boards into *Te Whatu Ora* [Health New Zealand] and *Te Aka Whai Ora* [Māori Health Authority]. Despite this, most peer support continues to be housed in Non-Government Organisations (NGOs), with uneven distribution across addiction and mental health services. Newer efforts include embedding peer support in multidisciplinary teams through flexible models, some co-located with NGO partners.

Policy and Infrastructure Timeline

- **Late 1980s–90s**: Deinstitutionalisation and early consumer movement (e.g., Light Minds campaign).
- **Late 1990s–2000s**: Mental Health Commission and recovery-oriented policy era; peer practice grows.
- **Pre-2000s**: Peer support begins informally within harm reduction, sex work, mental health sectors (e.g., New Zealand Prostitutes Collective, Needle Exchange).
- **2015**: *Te Kete Pounamu* [The Greenstone Basket] forms as national Māori lived experience network.
- **2017**: *He Ara Oranga* [Pathways to Wellness] inquiry recommends lived experience-led transformation.
- **2018**: Government commits to a Mental Health and Wellbeing Commission and peer involvement in suicide prevention.
- **2020**: *Pae Ora* [Healthy Futures] Act and Mental Health and Wellbeing Act introduced. Lived experience roles retained in the Ministry of Health, strengthening government insight.

- **2021**: *Kia Manawanui Aotearoa* [Long-Term Pathway to Mental Wellbeing in New Zealand] and *Oranga Hinengaro* [Mental Wellbeing] *Framework* published.
- **2021**: CPSLE Competency Framework launched by Te Pou [New Zealand's Centre for Mental Health Workforce Development].
- **2021–2023**: Use of unspent clinical budgets to create peer roles across multiple districts and specialties. Peer roles embedded in Emergency Departments and co-response pilots.

3. Enablers and Drivers for the Growth of Peer Support

Persistent Community Advocacy and Movement Leadership

- Peer support in Aotearoa New Zealand was built through decades of grassroots community activism and resistance, long before policy reforms were in place. *Tangata whai ora* [people seeking wellness] and whānau [family] consistently challenged exclusion from mental health decision-making, advocating for services that reflect lived realities and uphold cultural integrity.

- Advocacy for intersectional, community-led approaches has been critical, recognising that 'one-size-fits-all' does not work. There is increasing support for services that are designed and governed by communities themselves, enabling culturally safe, relevant, and effective peer and recovery support.

- The formation of *Te Kete Pounamu* [The Greenstone Basket] in 2015, a national network for Māori with lived experience, emerged in response to inequitable and restrictive mental health practices affecting Māori communities. This not only strengthened Māori-led peer support but also catalysed broader shifts in how peer support was understood and valued across Aotearoa New Zealand. In particular, elevating the visibility and legitimacy of lived experience leadership and helping to consolidate the notion that peer leadership was essential to systemic transformation, not supplementary. This bolstered advocacy efforts across all communities, making it harder for institutions to dismiss the value of lived experience in design and decision-making.

- This groundswell of advocacy laid the foundation for peer support to be recognised, resourced, and positioned as both a legitimate workforce and a pathway to community-led wellbeing. The emergence of national lived experience networks like *Te Kete Pounamu* [The Greenstone Basket], which partnered directly with government agencies to influence policy and strategy, further strengthened this momentum, creating new pathways for peer leaders, including those outside clinical or organisational settings, to contribute to system-level change.

Policy and Structural Reform

- Aotearoa's growth in peer support has been strongly shaped by landmark policy and legislation:
    - The *He Ara Oranga* [Pathways to Wellness] (2018) was a landmark inquiry that called for and placed lived experience and Māori leadership at the centre of mental health reform, triggering major policy and system shifts.
    - This led to the establishment of the Mental Health and Wellbeing Commission to provide independent oversight and monitor progress. While the Commission does not fund services, its mandate has helped keep focus on lived experience-led

transformation, which alongside government reforms has contributed to increased investment in peer-led and co-designed approaches.

- The *Pae Ora* [Healthy Futures] Act and Mental Health and Wellbeing Act (2020) legislated expectations for consumer and *whānau* [family] involvement and supported the inclusion of peer and lived experience leadership roles within government, notably within the Ministry of Health, reinforcing the legitimacy of peer and lived experience leadership across health.
- Strategic documents and national frameworks like *Kia Manawanui Aotearoa* [Long-Term Pathway to Mental Wellbeing in New Zealand] and the *Oranga Hinengaro* [Mental Wellbeing] Services and Systems Framework set out long-term pathways, with lived experience-led transformation explicitly framed as a key driver of change (Critical Shift 3).
- The Code of Expectations (a piece of secondary legislation) for health entities introduced and set out clear principles for engaging and involving people with lived experience across the health system, influencing commissioning, accountability, and service design.
- The CPSLE Competency Framework (2021), led and developed by Te Pou, laid the foundation for peer workforce development, standardising training, values, and supervision expectations.
- Government-backed pilots used unspent clinical vacancies to trial peer roles within multidisciplinary teams, demonstrating proof of concept and enabling peer inclusion in acute and community services.
- The role of system stewards, trusted individuals positioned within both community-led networks and policy/legislative spheres, has been pivotal in shaping the national direction of peer support.

Cultural and Community Leadership

- *Mātauranga Māori [Māori knowledge], Tuakana-Teina* [older sibling-younger sibling], and *Te Whare Tapa Whā* [the four cornerstones of Māori health] shape a relational, collective, and spiritual approach to peer support practice in Aotearoa New Zealand. These frameworks have helped centre whānau-led recovery and legitimise non-clinical ways of healing.
- Māori leadership has also helped push back against clinical gatekeeping and opened up more space for peer support to grow within services and policy. By challenging dominant models, modelling shared accountability through *whakapapa* (relational responsibility), and standing in solidarity with wider lived experience movements, Māori-led approaches have helped make peer support more visible, legitimate, and possible, especially in contrast to countries where no such Indigenous or pluralistic counter-narrative exists.
- Many *kaupapa Māori* [Māori-led] and peer run services were birthed from community need and draw on Indigenous practices rather than government frameworks. These services hold strong community trust but are often structurally underfunded due to systemic inequities in commissioning.
- Peer practice also emerged from movements where sustaining a community-grounded and rights-based approach was important.

- NGO-clinical partnerships, particularly in Māori and peer-led contexts, offer integrated models that reflect shared power and cultural practice.
- Clear role differentiation between direct peer support, systemic advocacy, and policy influence has helped sustain Māori and community-based contributions to system change.

Innovation and Service Design

- Peer support has been scaled and adapted across diverse settings, reflecting Aotearoa New Zealand's capacity for innovation:
    - *Tupu Ake* [To Grow Upwards], the country's first peer-led alternative to acute hospitalisation, remains a flagship example of community-driven innovation over 15+ years.
    - During COVID-19, digital peer support groups, peer-led vaccination outreach, and rapid investment in peer-governed services showcased the adaptability and effectiveness of peer approaches.
- Emergency Department based peer roles, co-response models (with ambulance and police), and peer-led alternatives like *Tupu Ake* [To Grow Upwards] represent innovation at the frontlines of care and were introduced to reduce emergency wait times and distress, aligned with ministerial goals.
- Most peer support remains NGO-based, enabling flexibility and community grounding but leaving gaps in integration, equity, and consistency.

Embedding Peer Roles in Systems

- Embedding lived experience roles in government (e.g., Ministry of Health) has ensured direct influence on policy, legislation, and system design and stewardship, an internationally significant approach.
- These roles allow *tangata whai ora* [people seeking wellness] insight to shape service frameworks, guide commissioning, and contribute to high-level decision-making, including within the machinery of government.
- Hybrid models of integration, such as multidisciplinary team pilots and regional placements, offer examples of peer roles working at the interface of community and system, bridging historically separate domains.
- There is growing integration of community-based practice and peer support within clinical settings, reflecting a hybrid approach where clinical teams and *Mata ora* (peer workers) work together to deliver holistic care.
- Differentiated peer roles (support, advocacy, systems change) ensure the peer identity is preserved and distinct from other clinical or support functions. It has strengthened peer identity and clarified influence across levels.

Accountability, Power and Challenges

- New structures such as the Mental Health and Wellbeing Commission play a key monitoring and accountability role but lack enforcement powers. They can issue recommendations and calls to action but cannot mandate change.

- Lived experience roles within government help bridge this power gap, amplifying community voice at senior levels. However, they come with emotional complexity, dual accountability, and limited structural support. Peer leaders in government roles must navigate tensions between influencing policy and remaining connected to grassroots movements, sometimes facing criticism or misunderstanding from both directions.
- Ongoing risks include the co-option of peer language or values, role erosion through assimilation into clinical roles, tokenism without real power to enact change. Protecting peer fidelity requires structural investment in education, supervision, reflective practice, and cultural leadership across all levels of the system.

4. Summary of What Was Found

The development of peer support in Aotearoa New Zealand reflects a deeply layered and evolving ecosystem, one that honours cultural wisdom, values lived experience and aspires to systems change. Today though it is wrestling with tensions of power, co-option, and structural rigidity.

Peer support emerged from activism, community practice, and marginalised movements, rather than from formal health systems. As a result, many peer-led initiatives maintain high fidelity to lived experience values but struggle for sustainable investment, particularly in Māori and *kaupapa*-led [Māori-led] services. Trust remains a major barrier for Māori communities engaging with government-led services, due to colonisation and ongoing cultural disconnection.

Government inquiry (*He Ara Oranga* [Pathways to Wellness]) and subsequent reforms triggered a wave of policy attention and investment, supporting the development of lived experience roles inside government, the creation of new funding streams, and expansion into new settings such as emergency departments and early intervention teams.

Although accountability mechanisms like the Mental Health and Wellbeing Commission play a critical role in monitoring system performance and amplifying lived experience insights, they are constrained by limited authority. While they can issue calls to action and public recommendations, these hold no legal force, meaning they rely heavily on personal influence, political will, and the strength of relationships with government agencies to prompt change. This creates a fragile dynamic. To enhance the credibility of their influence, the Commission has shifted language from "calls to action" to "recommendations" in an effort to add weight and urgency.

Aotearoa New Zealand lacks a funded, independent body to represent and mobilise peer support or *tangata whai ora* [people seeking wellness] leadership. This leaves a significant gap in the infrastructure needed to unify peer voices, hold systems accountable, and protect the distinctiveness and integrity of peer support from within the community. In practice, the burden of advocacy often falls to under-resourced networks and individuals, limiting sustainable momentum for change.

The growth of peer roles has not always been smooth. Early adopters faced resistance from clinical staff, particularly in acute and Emergency Department settings. Peer workers embedded in government settings often experience isolation from broader peer networks and tension around their dual roles. Yet their influence, when supported, can lead to direct legislative and strategic impact.

Aotearoa New Zealand's experience highlights the importance of embedding cultural, community-led approaches within peer support systems. The ability to bridge community networks and

political influence through trusted system stewards has strengthened the visibility and credibility of lived experience leadership. A hybrid model that brings together clinical and community-based practice is seen as central to improving outcomes and ensuring services meet the diverse needs of different groups.

A clear distinction has emerged between services *birthed from* lived experience and those merely *influenced by* it. The former are rooted in cultural and community wisdom and hold greater trust; the latter risk diluting peer identity or co-opting language without structural transformation. The rise of lived experience roles in government is a major win, but also creates new demands for protecting peer identity, enabling ongoing connection to community, and avoiding role erosion or tokenism.

Peer support in Aotearoa New Zealand is deeply enriched by Māori knowledge systems, mutuality models like *Tuakana-Teina* [older sibling–younger sibling], and holistic frameworks such as *Te Whare Tapa Whā* [the four cornerstones of Māori health]. These challenge dominant paradigms and offer more relevant approaches to recovery. However, merging peer roles with clinical functions or community support roles risks undermining their distinctiveness unless systems invest in shared understanding, supervision, and education.

The current moment is both hopeful and fragile. Peer roles are expanding in number, recognition, and diversity, but still require strong advocacy, cultural leadership, and infrastructure to realise their full potential.

Aotearoa New Zealand exemplifies a multifaceted and maturing peer support ecosystem. The interplay of systemic advocacy, cultural leadership, community practice, and insider policy roles offers powerful learning for other countries.

Key lessons include:

- Culture matters. Services must honour and reflect the cultural frameworks of the communities they serve.
- Strong infrastructure underpins peer fidelity, from training to supervision and leadership.
- Innovation thrives with time and support. Services like *Tupu Ake* succeeded because of long-term partnerships and peer-led planning.
- Trust must be earned, Government initiatives will falter without authentic community co-design, especially for Māori.
- Leadership belongs at all levels, from the community to government ministries.
- Protect peer identity and its distinctiveness. Peer roles must not be diluted or replaced by clinicians who happen to have lived experience.
- Embedding peers in systems must maintain their distinct knowledge, practice, and accountability to communities, striving for inclusion without assimilation.

"It has never been a better time to be a peer."

"One-size-fits-all doesn't work. Different communities have different needs. We need services within communities that are run by the communities themselves, so they can decide what's needed and how best to address it. Clinical teams and Mata ora [peer support] *can work together."*

5. Examples Peer Support Services in Aotearoa New Zealand

A. Tupu Ake (Counties Manukau)

- Aotearoa New Zealand's first peer-led alternative to acute inpatient care, embedded in community settings and run by NGO Pathways Health.
- With over 15 years of operation, it exemplifies long-term sustainability and fidelity to peer values, supported by clinical partnership and evaluation.

B. Multidisciplinary Team Integration Pilots (National)

- Government-backed initiative using unspent clinical FTE to embed peer workers in multidisciplinary teams across five districts in specialist mental health, addiction, maternal health, and youth services.
- Peers receive tailored scaffolding and supervision. Some roles remain co-located with NGOs.

C. Emergency Department Peer Roles:

- Recent expansion of peer roles into Emergency Departments following ministerial targets to reduce wait times and distress.
- Pilot projects are underway across multiple regions within *Te Whatu Ora* [Health New Zealand), reflecting efforts to integrate peer support into frontline crisis care.

D. Peer-Led Co-Response Teams:

- Pilots incorporating peers alongside police and ambulance in responding to 111 mental health crisis calls, offering a trauma-informed, rights-based alternative.

E. Thriving Madly and Te Kete Pounamu [The Greenstone Basket]:

- Lived experience knowledge networks and peer movements advocating from within and outside government systems.

Republic of Ireland

1. Key Messages

- **From grassroots to systemic integration**: Peer support in Ireland began in community-based projects and has since transitioned into formalised statutory roles. This shift exposed challenges in role definition, bureaucratic fit, and cultural acceptance, highlighting the need for ongoing cross-system learning and support.
- **Structured evolution**: Ireland's peer support journey has developed within a national recovery-oriented framework, shaped by a series of strategic policy shifts and organisational commitment.
- **Governance with accountability and limits**: The Independent National Implementation and Monitoring Committee (NIMC) plays a crucial role in overseeing recovery-oriented policy implementation, providing national-level accountability for peer support development. However, its advisory status means it lacks direct authority to enforce change, highlighting the continued need for strong local leadership and lived experience advocacy.
- **Formalised training and professionalisation**: Peer support workers are now formally recognised within the Health Service Executive (HSE), including through a newly designated grade code and a Level 8 university-accredited certificate in peer support.
- **Capacity building and co-production**: The HSE's MHER Office has played a central role in advancing co-production and lived experience leadership, now further embedded through initiatives such as the Centre of Excellence for Lived Experience.
- **Implementation still faces systemic barriers**: Despite notable policy progress and structural supports, peer support integration continues to face challenges due to systemic hierarchies and biomedical dominance.

2. Context

Ireland's mental health system has undergone significant transformation over the last two decades. Early shifts toward community-based, recovery-oriented services were initiated through *A Vision for Change* (2006), which called for the closure of traditional asylums and creation of community mental health teams. While not explicit about peer support, it opened the door to valuing experiential knowledge alongside clinical expertise.

Key policy influences were supported by international collaboration, particularly through Imroc in England. An event that brought Imroc representatives to Ireland helped inform local approaches to co-production, recovery education, and role clarity for peer support. Ireland's strategy, while independently developed, benefited from this cross-national learning.

Today, peer support roles exist across statutory and community settings, supported by recovery colleges, peer-led services, and national policy frameworks. Despite this progress, cultural and structural challenges persist in systems still shaped by biomedical traditions.

Ireland's mental health system has undergone significant transformation since the publication of *A Vision for Change* in 2006, a landmark policy that shifted the national focus from institutional to

community-based and recovery-oriented services. While this policy did not explicitly mention peer support, it laid the foundation for the movement by recognising the value of lived experience.

Following this, initiatives such as the Genio-funded *Advancing Recovery in Ireland (ARI)* programme catalysed early peer support roles. The ARI project, led in part by individuals with lived experience, eventually became a national programme supported by the HSE. In 2017, peer support roles were formally introduced into statutory mental health services, and by 2021, the role had a permanent funding stream.

The Mental Health Engagement and Recovery Office (MHER), established in 2019, and the creation of a Peer Support Worker grade code marked important milestones in the professionalisation of peer support in Ireland. Alongside this, the introduction of a QQI-accredited Level 8 Certificate in Peer Support at University of Dublin has reinforced the professional identity of peer workers.

Today, there are eight recovery colleges and education services, as well as growing peer-led services such as Involvement Centres, Gateway, and the Galway Community Café, which play an increasingly prominent role in the system.

Policy and Infrastructure Timeline

- **2006**: A Vision for Change published, setting out national mental health policy to shift from institutional care toward community-based, recovery-oriented services.
- **2008–2011**: Early recovery initiatives and service user councils emerge in some local services; the HSE and Mental Health Commission begin incorporating service user and family voices into quality improvement processes.
- **2012–2014**: Genio's Prosper Project and Advancing Recovery Ireland (ARI) pilot programmes introduce peer support roles in selected sites; Mental Health Ireland plays a key role in building capacity and advocating for recovery-focused, community-led models.
- **2013**: Refocus Project launched, strengthening service user involvement in service design and governance nationally.
- **2014–2015**: ARI begins expanding from pilot phase into the HSE system; early sites focus on developing recovery colleges, co-production models, and peer roles in collaboration with service users.
- **2016–2017**: Formal introduction of Peer Support Worker roles within HSE inpatient units and community mental health teams; development of peer role descriptions, recruitment pathways, and internal recovery champions to support local implementation.
- **2018–2020**: National Framework for Recovery in Mental Health launched, outlining national standards for embedding recovery and peer support in all services.
- **2019–2020**: QQI Level 8 Certificate in Peer Support established at University of Dublin, providing accredited peer training and formal qualification pathways.
- **2021–2022**: HSE introduces a dedicated Grade Code, formally recognising peer support as a distinct workforce discipline; efforts increase to roll out peer supervision models and strengthen workforce development.
- **2024–2028**: National Framework for Recovery in Mental Health updated with a new implementation plan, supported by the Independent National Implementation and Monitoring Committee (NIMC), to ensure consistent delivery and accountability across regions.

3. Enablers and Drivers for the Growth of Peer Support

Strategic Policy and System Reform

- Peer support development in Ireland has been underpinned by a long-term national commitment to recovery-oriented practice, beginning with A Vision for Change (2006). This foundational policy advocated for a shift from institutional care to community-based, person-centred services.
- Early pilots such as Genio's Prosper Project and the Advancing Recovery Ireland (ARI) initiative tested models of peer involvement within statutory services and informed future scaling.
- Refocus (2013) and the National Framework for Recovery in Mental Health (2018–2020) laid out structured pathways for integrating peer support into mental health systems. These frameworks embedded co-production principles, guiding both practice and policy.
- Launched in 2024, the updated National Framework for Recovery in Mental Health (2024–2028), monitored by the Independent National Implementation and Monitoring Committee (NIMC), provides continuity and accountability across political cycles, further embedding peer support into service expectations.
- NIMC brings together service users, carers, clinicians, and policymakers in a formal governance structure to monitor implementation of recovery and lived experience commitments.

Dedicated Infrastructure: Mental Health Engagement and Recovery Office (MHER)

- A critical driver of peer support development in Ireland has been the creation of the Mental Health Engagement and Recovery (MHER) Office within the HSE. Established in 2019, the MHER Office provided a dedicated structure for advancing recovery principles, co-production, and lived experience leadership across the national mental health system.
- Staffed by individuals with lived and family experience, the office has directly supported the expansion of peer support roles, recovery education, and national advisory mechanisms. It also acts as a central connector between community forums, Community Healthcare Organisation (CHO)-level engagement leads, and national planning processes. The office's visibility within the HSE has helped elevate peer support from project-based experimentation to a recognised component of national mental health reform.
- Its contribution to policy development, including the co-creation of the National Framework for Recovery in Mental Health and associated guidance documents, has been instrumental in institutionalising peer support as a core pillar of Ireland's recovery strategy.
- As part of its ongoing work, MHER has collaborated with Genio to co-develop a national Centre of Excellence for Lived Experience. This initiative aims to create a sustainable infrastructure for peer support and lived experience roles across the system providing national guidance on good governance, role design, supervision, training, and leadership development.

Professionalisation and Role Development

- The introduction of the QQI Level 8 Certificate in Peer Support (developed in partnership with Dublin City University) created a nationally recognised qualification for peer support workers and helped define the role's competencies.
- In 2022, the HSE formally introduced a peer support grade code, granting peer roles professional equivalence alongside other clinical disciplines.
- New leadership positions such as Peer Support Team Leader have provided clearer career development pathways, enhanced sustainability of the workforce and improving supervision structures.
- In early phases, national NGOs such as Mental Health Ireland played an instrumental role in hosting peer roles and employing recovery education staff. This arrangement enabled the sector to build capacity and pilot approaches while the HSE developed internal structures and formalised workforce pathways.
- Senior peer roles are being developed to support progression and ensure supervision is provided by experienced peers. National mapping of lived experience roles is also underway to inform guidance on competencies, induction, and governance structures, with attention to the emotional labour of peer work.
- Acting as an incubator, the NGO sector helped demonstrate the viability of peer-led education and paved the way for permanent contracts and grade codes.
- Government support for peer-specific training, including induction packages and alignment workshops for managers and teams, has fostered greater understanding and organisational readiness for peer integration.

Organisational Culture and Co-Production

- Ireland’s commitment to co-production, inspired in part by England’s Imroc model, has helped embed lived experience into every level of service design, delivery, and evaluation.
- The HSE’s Mental Health Engagement and Recovery Office (MHER) has played a key role in operationalising co-production, supporting advisory groups, and ensuring that lived experience is integrated across frameworks and planning.
- Co-production has become increasingly embedded in everyday planning and governance, evolving from an aspirational principle into a system-wide expectation. Reference groups routinely challenge service leads to demonstrate the meaningful involvement of lived and family experience, with co-production now considered a standard requirement in the development of new services, frameworks, and strategies. This expectation has helped create shared accountability for embedding recovery values across all tiers of mental health delivery.
- Variability in team readiness continues to challenge peer integration. To support cultural change, co-produced induction resources such as orientation videos featuring peer and clinical perspectives have been introduced. Recognising lived experience as a form of expertise and preparing teams accordingly are increasingly seen as essential.
- Service user input now shapes induction materials, supervision models, and workforce strategies, reflecting a broader cultural shift toward valuing lived experience as a form of expertise.

- Short courses and leadership alignment meetings support wider system understanding of peer support roles and promote shared accountability for embedding recovery values.

Navigating System Integration

- The transition of peer support roles from grassroots and community settings into HSE-run services brought structural and cultural challenges. These included ambiguity around job roles, inconsistent supervision, and varying levels of staff buy-in.
- Misunderstandings of peer roles by colleagues have been addressed through structured training, multi-disciplinary collaboration, and reflective practice initiatives, though cultural change remains a work in progress.
- Organisational learning continues to be essential, particularly around supporting peer-led supervision and ensuring clear expectations and peer-specific role fidelity in clinical environments.
- Peer workers have initiated communities of practice to reduce isolation and support reflective learning. Annual gatherings and regional alignment meetings strengthen cohesion and help connect peer roles with recovery education and engagement efforts across the system.

Community-Based and Innovative Practice

- Ireland's recovery colleges offer co-produced learning environments where courses are delivered by peers and professionals, helping build both individual recovery and peer workforce capacity.
- Peer-led initiatives such as Gateway, Áras Folláin, and the Galway Community Café demonstrate alternative, non-clinical models of peer support that foreground mutuality, social connection, and emotional safety.
- Recovery education has been used as a cultural lever within statutory services, creating opportunities for reflective practice and values alignment. Programmes such as the Recovery Principles and Practice workshop, co-produced and co-delivered by peers, clinicians, and family members, offer space for multidisciplinary teams to explore recovery values and clarify the role of peer support. These workshops have played a vital role in preparing services for peer integration, shifting organisational cultures, and reconnecting staff with the purpose of person-centred mental health care.
- These examples provide important counterpoints to clinical service delivery and continue to inform national conversations about peer respite and crisis alternatives.

4. Summary of What Was Found

Ireland's journey reflects a deliberate and evolving approach to embedding peer support in mental health services. Key infrastructure such as policy frameworks, professional training, and organisational commitment has been put in place. At the same time, cultural challenges persist, particularly in navigating the tensions between hierarchical, biomedical models and the radical, relational ethos of peer support.

Progress has been steady but incremental. From a single peer support worker in a Genio pilot to a national workforce with dedicated training and grade codes, the development has been shaped by advocacy, co-production, and policy learning.

Structural fragility remains an ongoing risk. Recent shifts in the governance of health services, including the reorganisation of the HSE into six new Regional Health Authorities, have introduced uncertainty about where mental health services, and specifically the Office for Mental Health Engagement and Recovery will sit. There are concerns that peer support and recovery-oriented functions may be deprioritised or subsumed into broader service portfolios, weakening their visibility and autonomy. This highlights the importance of statutory protection, clear funding lines, and continued investment in dedicated lived experience infrastructure.

Despite this, peer workers still encounter misunderstandings of their roles and resistance from some clinical colleagues. There have also been bureaucratic challenges in integrating peer support workers into the HSE system, particularly as roles shifted from grassroots, community-based initiatives to formalised statutory settings. These barriers have implications for peer workers' wellbeing and sustainability in the workforce, pointing to the need for ongoing education and cultural change across all tiers of mental health systems.

"Peers are radical. They're meant to be radical... There's no hierarchy."

The Independent National Implementation and Monitoring Committee (NIMC) has created an important layer of policy accountability, ensuring that lived experience and peer support commitments within national frameworks are monitored and tracked. Its support of the *National Framework for Recovery in Mental Health (2024–2028)*, including the development of implementation indicators, has helped institutionalise recovery principles. However, its lack of executive power to direct HSE practice means its impact depends on strong partnerships and local follow-through. This reinforces the importance of co-produced leadership and peer advocacy across all tiers of the system.

Ireland's experience shows that meaningful implementation of peer support requires sustained investment in capacity building, co-production, and structural reform. National bodies like the NIMC contribute significantly to transparency and oversight by monitoring progress against recovery-focused goals. However, their impact depends on strong collaboration across the system to turn policy into lived experience-led change. While the policy environment is strong, the culture of mental health services is still in transition. National bodies like the NIMC contribute significantly to transparency and oversight but depend on system-wide cooperation to achieve sustainable peer-led change.

Key lessons include:

- Start with co-development. Policy and programmes built with those with lived and family experience from the outset are more likely to succeed.
- Build capacity deliberately, developing a diverse, confident, and reflective peer workforce takes time, but creates resilient systems.
- Support ongoing learning through reflective practice, refresher training, and leadership development. These are critical to maintaining the emotional sustainability of peer roles.
- Create space for radical approaches. For peer support to thrive, mental health systems must challenge traditional hierarchies and create space for values-based, relational work.

- Build and diversify capacity. Sustained investment in a broad, representative network of peer workers, educators, volunteers, and advisors helps embed recovery approaches and protect against policy backsliding. Deliberate outreach to underrepresented groups, has strengthened the inclusiveness and credibility of co-production efforts. *"Once you have your capacity… there's no turning back."*

"We're now at the stage where the service would be missed… the voice is loud enough."

5. Examples of Peer Support Services in Ireland

A. Kyrie Farm Peer Respite

- A peer-led respite service that provides short-term, voluntary support for people experiencing emotional distress in a therapeutic community environment.
- Operates as a home-like alternative to clinical intervention, emphasising connection, self-determination, and recovery values.
- Based in a rural setting, it offers a tranquil environment grounded in peer support principles and lived experience leadership.

B. Gateway and Tipperary Peer Support (formerly Áras Folláin)

- Peer-led centres that offer workshops, social groups, and recovery supports.
- Evaluations show increased social engagement and improved coping strategies among participants.

C. Galway Community Café

- An out-of-hours, peer-led service for people in distress, co-located with a commercial café to promote informality and comfort.
- Designed explicitly to be a non-clinical space that fosters presence, shared experience, and relational support.

D. Recovery Education Services and Colleges

- Eight centres across Ireland support both service users and staff through recovery-focused learning.
- Courses often co-delivered by peer educators and clinicians, embodying co-production in practice.

E. Centre of Excellence for Lived Experience

- Developed in collaboration with Genio and MHER, it aims to support leadership development, research, and national infrastructure for peer support and engagement.

F. Peer Support Worker Certificate Programme – Level 8 (University of Dublin)

- Formal qualification requirement for peer workers employed in HSE services.
- Includes reflective practice, recovery principles, and peer theory.

Victoria, Australia

Australia's size and federated governance mean mental health policy and service delivery vary significantly across states and territories. This report focuses on Victoria, a state widely regarded as a national leader in embedding lived experience and peer support into mental health reform. By focusing on Victoria, we can highlight lessons relevant to other systems, particularly in how peer support can act as a lever for cultural and structural change.

1. Key Messages

- **Political support with a Royal Commission as a catalyst**: The 2021 Royal Commission into Victoria's Mental Health System marked a turning point, embedding peer support into state-wide mental health reform and prioritising lived experience as a core element of system transformation.
- **Workforce expansion and professionalisation**: Victoria has invested in the growth of the peer workforce through dedicated formal training pathways, such as the Certificate IV in Mental Health Peer Work, and workforce development initiatives like the Lived Experience Peer Cadet Program.
- **Peer support as a lever for cultural change**: Peer support roles are seen not merely as service functions, but as essential for shifting organisational cultures toward recovery-oriented, person-centred care. This has been explicitly supported through frameworks, guidelines, and the establishment of senior lived experience roles.
- **Community advocacy and grassroots leadership**: Sustained advocacy from the lived experience community, combined with formal mechanisms for co-production, has ensured that peer leadership is represented not only in service delivery but also in governance and system design.
- **Leadership infrastructure as an ecosystem, not just roles**: Victoria's approach has intentionally built a pipeline of lived experience leadership spanning peer supervision, senior governance roles, and cultural influencers, creating an environment where peer support is practiced, supported, and modelled at every level.
- **Ongoing challenges around diversity, inclusion, and implementation gaps**: Despite strong policy frameworks, Victoria faces persistent challenges, including underrepresentation of Indigenous and culturally diverse communities, tensions between policy ambition and frontline realities, and the risk of tokenism in peer roles.

2. Context

Victoria's mental health system has undergone profound transformation over the past decade, driven by sustained public pressure, grassroots activism, and political leadership. Victoria has emerged as a national leader in embedding lived experience into mental health reform.

The state's approach to peer support is underpinned by a long tradition of consumer and carer advocacy dating back to the 1970s and 1980s, when individuals with lived experience began organising in response to institutional abuses, compulsory treatment, and exclusion from decision-making.

The Royal Commission into Victoria's Mental Health System (2019–2021) was established after widespread public concern and political recognition that the mental health system was failing to meet community needs. The Commission's final report, delivered in 2021, described the system as "crisis-driven," fragmented, under-resourced, and inequitable, and called for transformative change, including embedding lived experience across all levels of design, governance, delivery, and oversight.

The Royal Commission made 65 recommendations, all accepted by the Victorian Government. A core theme was the recognition of lived experience as essential to reform, leading to the creation of lived experience governance bodies, peer workforce expansion, and the appointment of a Lived Experience Commissioner.

Victoria also benefits from a wider national context of policy and reform. The Australian Government's National Mental Health Strategy and Fifth National Mental Health and Suicide Prevention Plan (2017–2022) explicitly acknowledge the role of lived experience and peer work, though implementation largely falls to states and territories. Victoria has consistently been seen as a national leader in operationalising these commitments.

However, significant challenges remain. Structural inequities, including the impacts of colonisation on Aboriginal communities, have meant that Indigenous voices are underrepresented in the peer workforce. There is also a need to strengthen the representation of culturally and linguistically diverse (CALD) communities, as well as LGBTQIA+ communities, in both peer roles and leadership.

Although the Royal Commission marked a catalytic turning point, much of Victoria's momentum was seeded years earlier through sustained advocacy, ministerial advisory groups, and relationship-building between consumer leaders and government. This long-term groundwork meant that lived experience was not only included in the Royal Commission's recommendations but was structurally embedded in their implementation, including the appointment of commissioners with lived experience backgrounds.

Policy and Infrastructure Timeline

- **2014**: Enactment of the Mental Health Act 2014, which introduced rights-based protections and established the Mental Health Complaints Commissioner.
- **2015–2016**: Victoria's 10-Year Mental Health Plan set a vision for a more inclusive, recovery-oriented system, including commitments to expand the lived experience workforce.
- **2018**: Publication of *Peer Work in Australia: A New Future* by Mind Australia, which helped articulate the value of peer work nationally and frame lived experience as a legitimate and transformative workforce.
- **2019–2021**: Royal Commission into Victoria's Mental Health System conducted; received over 12,500 contributions and held 65 days of hearings. Ministerial Advisory Committees involving consumer peak bodies helped shape the scope and emphasis of the Royal Commission's inquiry, increasing the visibility of lived experience voices in system planning.
- **March 2021**: Royal Commission final report released, recommending a new mental health system with lived experience leadership at its heart.
- **2021–2024**: Implementation of the Mental Health and Wellbeing Workforce Strategy, focused on multidisciplinary workforce growth, including peer roles.

- **2022**: Establishment of the Mental Health and Wellbeing Division and appointment of lived experience leaders, including the Lived Experience Commissioner.
- **2023**: Launch of the Lived Experience Peer Cadet Program, providing part-time paid roles alongside study in the Certificate IV in Mental Health Peer Work. Significant lived experience expansion at Alfred Hospital, growing from 5 to over 70 roles in five years without external funding, becomes a flagship example of whole-of-system lived experience integration in a clinical setting.

3. Enablers and Drivers for the Growth of Peer Support

Political Leadership and System-Level Commitment

- The 2021 Royal Commission into Victoria's Mental Health System was the defining catalyst for embedding peer support into Victoria's mental health reform. The Commission explicitly called for lived experience to be positioned at the heart of the system, recognising it as essential for addressing past failures and building a recovery-oriented, rights-based mental health system.
- The Victorian Government's acceptance of all 65 recommendations, combined with budget commitments, gave peer work unprecedented political legitimacy. This political will extended to the creation of a Lived Experience Commissioner, who holds an official governance role and symbolises the government's long-term commitment to lived experience leadership.
- Peer advocates strategically used the timing and visibility of the Royal Commission to shift policy, aligning "hearts-and-minds" advocacy with high-level political opportunity. This convergence of political receptivity and lived experience leadership was crucial to embedding peer support into the system's reform blueprint.

Policy Frameworks and Strategic Guidance

- Victoria's reform journey has been guided by a suite of strategic frameworks, including the Mental Health Lived Experience Engagement Framework and the Consumer and Family Carer Discipline Framework. These were co-produced with lived experience leaders and provide clear guidance for service providers, policymakers, and health organisations on how to engage lived experience meaningfully.
- The Mental Health and Wellbeing Workforce Strategy 2021–2024 explicitly prioritises the development, integration, and sustainability of the peer workforce, recognising peer roles as part of a multidisciplinary response to mental health needs.
- Importantly, Victoria has framed peer support not as an "add-on," but as a central mechanism for shifting organisational culture, strengthening accountability, and improving service user outcomes.
- Peer-led initiatives such as PACE's *Connection and Community* framework signal a shift toward lived experience leadership not only in service roles but in the architecture of service design. These approaches extend peer values beyond traditional roles to reshape how mental health crisis and distress are conceptualised, governed, and responded to.

Workforce Development and Professionalisation

- Workforce initiatives such as the Certificate IV in Mental Health Peer Work have been crucial in formalising peer roles, providing peer workers with a nationally recognised qualification that strengthens their professional identity and credibility within clinical and community services.
- The Lived Experience Peer Cadet Program offers structured pathways into employment, combining paid part-time work with study, ensuring that emerging peer workers gain hands-on experience alongside formal learning.
- Victoria has also invested in discipline-specific supervision, including the Consumer Perspective Supervision (CPS) courses, written and facilitated by experienced peer leaders. This has helped address a longstanding challenge in the field: providing supervision that recognises and nurtures the unique values and challenges of peer work.
- Victoria's peer workforce expansion has been underpinned by deliberate efforts to build a full ecosystem of lived experience roles from entry-level peer workers to senior leadership positions, supported by a rare level of funding (on a per capita basis) compared to other systems globally. This has been framed as a "once-in-a-generation" opportunity to embed peer work within organisations at all levels, rather than treating it as an isolated role or programme.
- Training programmes such as the Consumer Perspective Supervision (CPS) course, co-developed and delivered by experienced peer leaders, have helped build a formal supervision infrastructure that supports peer-specific values, reflective practice, and professional development. This infrastructure also helps senior peer leaders remain connected to frontline practice, supporting continuous learning and grounded leadership.
- Equity concerns have been raised about who is accessing these workforce opportunities. Despite formalised pathways, Indigenous, migrant, and LGBTQIA+ communities remain underrepresented in peer roles. Without deliberate strategies for inclusion, there is a risk that peer work will replicate the systemic inequities it aims to challenge.

Organisational and Service-Level Integration

- Many Victorian health services and NGOs, such as Barwon Health and Mind Australia, have established formal peer roles within crisis response teams, inpatient units, community services, and early intervention programmes. This integration reflects a commitment to embedding peer perspectives across the entire continuum of care.
- Peer support has been positioned not only as a service enhancement but as a driver of organisational change, helping shift teams toward recovery-focused, trauma-informed, and person-centred practice. Organisations have increasingly adopted co-production in programme design, policy development, and evaluation, although the extent and quality of this vary between services.
- Over five years, the Alfred Hospital grew its peer workforce from five to over 70 lived experience roles, including senior leaders and directors, without receiving additional external funding. This transformation was driven by values-based leadership from the clinical director and executive team, who committed to embedding lived experience throughout service delivery, governance, and workforce structures. The hospital now offers peer-specific supervision and leadership development across all levels, providing a working model of whole-system peer integration in a hospital setting.

- Senior peer leaders have intentionally engaged external peer consultants and facilitators particularly when delivering training or influencing boards, to ensure ideas are received independently of internal organisational dynamics. This strategy has strengthened internal legitimacy, improved cultural receptivity, and built credibility with executive stakeholders.

Grassroots and Community-Based Advocacy

- Victoria's peer support movement has been shaped by decades of advocacy from consumer- and carer-led organisations, which have worked to challenge biomedical dominance, push back against coercive practices, and create spaces for rights-based, person-led recovery.
- Organisations such as Peach Tree Perinatal Wellness demonstrate the power of grassroots, peer-led service design, offering community-driven models of support that prioritise prevention, early intervention, and relational connection.
- Grassroots leaders have also played a critical role in shaping public discourse, with senior peer leaders regularly contributing to media, public forums, and professional development training to promote the value of lived experience.

Cultural Change and Symbolic Leadership

- The presence of high-profile peer leaders in senior positions, including the Lived Experience Commissioner has had a symbolic and practical impact, inspiring hope, demonstrating the transformative power of recovery, and shifting community and service perceptions of people with lived experience. *"You can be on a compulsory treatment order one moment of your life, but it's only one component of who you are… but you too can be commissioner."* This message has had a ripple effect, normalising peer leadership as an aspirational and achievable path for people with lived experience.
- Victoria's peer leaders have played a critical role in modelling inclusive, relational approaches to leadership that span government, services, academia, and grassroots communities. Their bridging capacity has enhanced trust, accountability, and system credibility, demonstrating that peer leadership can act as a catalyst for cultural and structural change.
- Cultural frameworks that acknowledge the distinct lived experiences of First Nations peoples remain underdeveloped. Addressing systemic racism and the impact of colonisation requires specific roles, supports, and leadership strategies designed by and for Indigenous communities. Consumer representation also remains dominated by white, academic voices, highlighting the need to diversify system-level leadership and governance.

4. Summary of What Was Found

Victoria has emerged as one of the most progressive jurisdictions in Australia for embedding lived experience and peer support into its mental health system. The state's approach has been shaped by a combination of high-level political commitment, system reform, grassroots advocacy, and targeted workforce investment, creating a uniquely fertile environment for peer support to grow.

The Royal Commission into Victoria's Mental Health System (2021) was a defining milestone, positioning lived experience and peer support not as supplementary elements but as essential to

system transformation. This commitment has been operationalised through governance innovations like the Lived Experience Commissioner role, as well as through co-produced frameworks such as the Mental Health Lived Experience Engagement Framework and the Consumer and Family Carer Discipline Framework. These reforms have helped build legitimacy, structure, and momentum for lived experience involvement across policy, practice, and workforce development.

Although there is no shortage of frameworks and documents at both national and state levels, there is a lack of a unified, binding competency or accountability framework. This has created inconsistency in practice quality and exposed the workforce to variation in training, supervision, and values alignment. A clearer national or state-endorsed standard could help consolidate peer work as a recognised discipline.

At the service delivery level, peer support is now integrated across inpatient care, crisis services, community mental health, and prevention and early intervention programmes. The development of training pathways like the Certificate IV in Mental Health Peer Work and initiatives such as the Lived Experience Peer Cadet Program have supported the professionalisation of the peer workforce. Meanwhile, discipline-specific supervision models, particularly Consumer Perspective Supervision (CPS), have been critical in safeguarding role integrity and practice quality.

Key findings include:

- Policy and governance have created momentum, but implementation is uneven. Victoria has generated strong political and policy commitments to peer support, but the pace and consistency of implementation vary across services and regions.
- Lived experience leadership has been transformative. The visibility of peer leaders in senior governance roles has been pivotal in shifting cultural attitudes, providing hope, and opening new pathways for leadership and influence.
- Frameworks are plentiful but sometimes outpace practice. While Victoria has produced an impressive array of lived experience frameworks and guidelines, translating these into consistent, meaningful practice at the ground level remains a work in progress.
- Diversity and inclusion remain critical challenges. The peer workforce is still not representative of Victoria's cultural and social diversity, particularly lacking adequate inclusion of Aboriginal and Torres Strait Islander communities, migrant and refugee populations, and LGBTQIA+ groups.
- Workforce development and supervision are essential enablers. Training pathways, peer cadet programmes, and consumer-specific supervision have strengthened role clarity and sustainability, but scaling these efforts will be essential to meet future demand.
- Economic pressures have slowed reform momentum. The COVID-19 pandemic and subsequent budget constraints have delayed the implementation of several Royal Commission recommendations, raising concerns about maintaining reform progress.
- The presence of strong political commitment and grassroots leadership has enabled a uniquely well-funded and structured lived experience ecosystem, but risks remain around equity, over-professionalisation, and sustainability of reform beyond current leadership cycles.

Victoria's experience demonstrates the powerful potential of combining political will, lived experience leadership, structural reform, and workforce development to embed peer support into a mental health system. The state has made substantial progress in creating a system where lived

experience is valued not only as a support function but as a catalyst for cultural and systemic change.

Despite the significant achievements, there are still concerns about the long-term sustainability of these gains, such as the risk of peer roles being seen as a "moment in the sun"; a temporary innovation vulnerable to reversal in times of political or economic change. The peer leadership infrastructure, though symbolically and practically powerful, remains contingent on continued political and institutional support.

Closing the gap between policy ambition and practice, ensuring the peer workforce reflects the diversity of Victorian communities, and protecting the reform agenda from budget and political pressures will be crucial to fully realising the transformative potential of peer support.

This spirit of hope and transformation has become a hallmark of Victoria's approach, offering both inspiration and lessons for jurisdictions across Australia and internationally.

5. Examples of Peer Support Services in Victoria

A. Lived Experience Commissioner (Victoria)

- Provides statewide lived experience leadership at the governance level.
- Engages directly with consumers and carers, ensuring system accountability and visibility of peer voices.

B. Barwon Health Mental Health and Wellbeing Hub

- Integrates peer support workers into crisis response, early intervention, and multidisciplinary teams.
- Offers an innovative model combining clinical and non-clinical expertise in acute care settings.

C. Peach Tree Perinatal Wellness

- A pioneering, peer-led organisation supporting new and expecting parents through early intervention, support groups, and community-based programming.
- Founded from grassroots beginnings, Peach Tree has evolved into a respected model of rigorous, community-based peer support. It offers programmes on parenting after loss, 'mums-and-bubs yoga', and trauma-informed peer groups.
- It exemplifies how peer values can be applied to prevention and perinatal care, while still meeting programmatic, clinical, and governance standards. It demonstrates the potential for well-designed peer-led services outside traditional mental health settings.

D. Lived Experience Peer Cadet Program

- Provides paid, part-time employment linked to Certificate IV study.
- Builds a sustainable pipeline of trained peer workers ready for entry into the mental health workforce.

E. Consumer Perspective Supervision Courses

- Provides discipline-specific supervision training written and delivered by peer leaders.
- Ensures peer workers have access to meaningful, lived experience-based supervision and career development.

F. Alfred Hospital Lived Experience Workforce Integration

- Grew from 5 to over 70 lived experience roles in five years without new external funding.
- Embedded lived experience leadership across governance, clinical teams, and supervision structures.
- Offers a replicable model of embedding peer support across the hospital system through committed executive and clinical leadership.

Wales

1. Key Messages

- **From fragmentation to infrastructure**: Since 2020, Wales has progressed from having scattered, unsupported peer roles to building the foundations of a more coordinated, nationally recognised peer support infrastructure. Milestones such as the launch of Cardiff and Vale Recovery College and the appointment of the first Band 7 peer lead have catalysed visibility and system-wide conversations.
- **Local proof is driving policy change**: Concrete examples of peer-led work, especially in Cardiff, have played a pivotal role in influencing policy and unlocking government support. Ministerial visits and stakeholder engagement have turned grassroots innovation into formal policy action, including peer workforce commitments in the Health Education and Improvement Wales (HEIW) and Social Care Wales Strategic Workforce Plan.
- **Recovery colleges as system changers**: Recovery colleges in Wales, when genuinely peer-led and co-produced, have served as transformative spaces for both people and institutions. Beyond personal recovery outcomes, they have shifted how services understand lived experience, helped embed co-production, and fostered broader system culture change.
- **Autonomy enables and restricts progress**: Wales's seven autonomous health boards allow for locally tailored approaches but also result in patchy implementation and inconsistent investment. Without mandatory standards or oversight, the success of peer support often hinges on local leadership and relational advocacy rather than national levers.
- **Funding fragility limits sustainability**: Most peer roles remain outside core staffing structures and rely on temporary or discretionary funding. In times of fiscal constraint, they are often among the first roles questioned or cut, especially by executive decision-makers unfamiliar with their distinct value.
- **Cultural and linguistic relevance matters**: The emotional significance of the Welsh language particularly in North Wales, has elevated the need for culturally grounded, bilingual peer support. The planned Welsh-language recovery college represents a major step toward more inclusive and resonant service models.
- **Allied support, leadership tensions**: Occupational therapists, psychologists, and public health professionals have been essential allies in peer support development. However, even these professions can struggle to cede leadership, with some recovery models still leaning toward professional dominance rather than lived experience-led practice.

2. Context

Peer support in Wales has developed relatively late compared to some other nations, with the most significant advances emerging post-2020. Despite a prior decade of interest in recovery-oriented mental health services, peer roles in Wales remained isolated, inconsistently implemented, and largely unsupported through formal infrastructure. Peers in NHS roles often had no access to specialist training or peer supervision, and clinical managers frequently lacked the experience to support them effectively.

This began to shift during the early stages of the COVID-19 pandemic, when emergency innovation funding enabled the creation of the Cardiff and Vale Recovery College. Established as the first NHS-based, peer-led and co-produced recovery college in Wales, it provided tangible evidence of impact that garnered political attention. Ministerial visits to the college catalysed a shift in perception, transforming peer support from a concept of interest to a credible, fundable intervention.

"It's 'see it to believe it.' Once people experience it, they realise it's not a threat."

This concrete example helped drive the formation of a peer-led task group within NHS Wales which successfully advocated for the inclusion of lived experience roles and recovery college models within the 2023 HEIW and Social Care Wales Strategic Workforce Plan (notably Actions 18 and 19). This was a turning point, providing the peer workforce with a national policy anchor for the first time.

Yet the system in Wales remains characterised by a high degree of regional variation. Health boards have significant autonomy, which allows for local innovation but can also lead to fragmentation. While regions like Aneurin Bevan and Cardiff and Vale have made substantial progress, others remain at much earlier stages of development or lack dedicated infrastructure. The absence of mandatory standards or national oversight means that lived experience roles are often developed through personal advocacy and local leadership rather than systemic drivers.

Financial precarity also continues to threaten progress. Most peer roles are not embedded within core staffing structures and are instead funded through short-term or external sources, such as transformation grants. As such, peer roles are often excluded from decision-making about essential staffing needs and are at risk during periods of fiscal tightening. Clinical executives and finance leaders, who may lack understanding of peer support's distinct value, are often final gatekeepers in recruitment and continuation decisions.

Culturally, Wales is beginning to recognise that peer support must reflect the language and identity of its people. For many, Welsh is the emotional first language, and mental health support that is not culturally or linguistically appropriate may fall short. Efforts are now underway to create a bilingual Welsh-language recovery college in the Betsi Cadwaladr region and to ensure future national resources are co-produced in both Welsh and English.

Policy and Infrastructure Timeline

- **2012**: Early traction of recovery-oriented principles. First informal peer support roles appear in some mental health services.
- **2017**: Aneurin Bevan Health Board pilots "peer mentors," led by psychologists on temporary budgets.
- **2020**: Cardiff and Vale Recovery College launches, funded through COVID-19 transformation monies. First Band 7 peer leader role introduced in NHS Wales.
- **2021–2023**: Peer-led task and finish group influences the development of the national mental health workforce strategy.
- **2023**: Health Education and Improvement Wales (HEIW) and Social Care Wales publish Strategic Workforce Plan, with Actions 18 and 19 embedding lived experience workforce and recovery college development.
- **2024**: Temporary Band 7 peer leadership roles funded in each health board to develop regional recovery college business cases.

- **2024+**: Welsh-language recovery college planned in Betsi Cadwaladr UHB; focus on supervision frameworks, infrastructure, and evaluation across Wales.

3. Enablers and Drivers for the Growth of Peer Support

Strategic Policy Inclusion and Ministerial Engagement

- The Health Education and Improvement Wales (HEIW) and Social Care Wales Strategic Workforce Plan (2023) was a pivotal policy lever. It explicitly included lived experience roles and recovery colleges within national workforce priorities, providing a reference point for regional funding and recruitment efforts.
- Ministerial visits to the Cardiff and Vale Recovery College helped shift perceptions at the highest levels, demonstrating peer support as credible, scalable, and politically attractive.

Leadership and Advocacy from Within

- Strong leadership from lived experience professionals, especially those in NHS Band 7 and 8A roles, has driven development from within the system. Strategic secondments have enabled peers to contribute directly to planning, infrastructure, and workforce development.
- These leaders built “hearts and minds” support by collecting allies across occupational therapy, psychology, and public health.

Concrete Models and Relationship-Based Influence

- The Cardiff and Vale Recovery College served as a tangible and successful proof of concept that could be replicated. Its model, built with co-production, demonstrated peer support's practical and emotional value.
- The Aneurin Bevan model of psychologist-led “peer mentors” also evolved over time into formal peer roles with appropriate banding and increasing autonomy.

Use of Temporary and Flexible Funding to Innovate

- COVID-19 transformation funding enabled rapid innovation, including the founding of the Cardiff recovery college. This use of time-limited money created space for experimentation without displacing existing services.
- While precarious, this funding approach helped “de-risk” peer support for cautious leaders and allowed time to build trust and evidence.

Welsh Identity and Cultural Relevance

- Cultural specificity is increasingly seen as a strength. The commitment to a Welsh-language recovery college, and collaboration with the Welsh Language Commissioner, represents a broader move toward culturally grounded models.
- Emotional expression is often rooted in first language, and recognition of this has shaped emerging models of delivery in North Wales.

4. Summary of What Was Found

Wales's peer support development has been shaped by a confluence of strategic advocacy, grassroots innovation, and cultural reawakening. From a baseline of isolated and unsupported peer roles in 2019, Wales has, in just a few years, built a foundation that is recognised at national policy levels, supported by emerging infrastructure, and visible to ministers and decision-makers.

One of the most important lessons from Wales is that visible, peer-led innovations like the Cardiff and Vale Recovery College, can shift perceptions and policy when coupled with strategic relationship-building. The success of the college offered a concrete demonstration that peer support could be impactful, deliverable, and aligned with system values. This enabled advocates to move from "hearts and minds" to strategic policy inclusion.

Another finding is the critical role of peer leadership within the system. Strategic secondments and higher-banded peer roles (e.g. Band 7 and 8A) were necessary to shift cultural norms and open space for workforce planning. Without peers in those roles, it's unlikely that peer support would have been written into national workforce strategy or funded across all seven health boards.

Wales's small population and devolved health system also created a unique dynamic: change could move quickly if a few key people were aligned, but risked fragmentation in the absence of strong central coordination. The current model relies heavily on relationships, local champions, and discretionary interpretation of national guidance. While this allows for adaptation to local needs, it also risks inequity in access to peer support depending on geography.

Funding remains both an enabler and a vulnerability. Peer roles have typically been funded through temporary pots: COVID transformation monies, innovation grants, or time-limited strategic investment. While this has allowed experimentation, it also leaves peer roles vulnerable. At times, funding has not been renewed, and roles have been lost.

"It's not a clinical decision anymore, it's an accountancy decision whether that role is kept."

Cultural and professional dynamics also continue to shape progress. Some professional groups, have resisted full integration of peer leadership, citing clinical scope or statutory responsibilities. Others, such as Psychologists and Occupational Therapists, have been more open allies, often due to their own experiences of lived experience or recovery-oriented practice.

Peer support is now increasingly seen as something that "works," but the system still grapples with what it means for peer roles to be essential. Until peer workers are embedded in core workforce plans and establishment numbers, they will remain at risk in periods of austerity. Further work is needed to embed supervision, define role boundaries, and develop formal training and evaluation pathways.

"It's often easier politically to support peer work when it's seen as new, innovative, and not part of the core budget, but that also makes it vulnerable."

A final lesson from Wales is the importance of cultural grounding. The planned Welsh-language recovery college, and moves to co-produce bilingual national resources, mark an important step in ensuring peer support speaks to the identities, histories, and emotional lives of the people it serves. Wales may have started late but it is now uniquely positioned to lead on culturally and linguistically inclusive peer support models.

Key Lessons Learned

- Policy levers are most effective when coupled with real-world, visible models of peer support.
- Strategic leadership roles for peers within the system are essential to shift culture and policy.
- Financial fragility is a major barrier to sustainability; core budget integration is needed.
- Regional autonomy enables innovation but requires national coordination to ensure equity.
- Cultural and linguistic alignment increases the depth and resonance of peer support.
- Concrete evidence and personal experience remain the most persuasive advocacy tools.
- Peer roles must be viewed not just as additions, but as integral components of mental health systems.

"Peer leadership can still be challenging even to professional groups that are really supportive… they like the idea of it, but they want it to be led by them."

5. Examples Peer Support Services in Wales

A. Cardiff and Vale Recovery College

- The first NHS-based recovery college in Wales, launched in 2020, remains the cornerstone of peer support infrastructure.
- The model emphasises co-production, empowerment, and cultural change from within the NHS.
- The college also became a key reference point in workforce policy and ministerial engagement, contributing to national recognition of peer roles.

B. Aneurin Bevan University Health Board Peer Support Workforce

- Peer roles first appeared in Aneurin Bevan UHB in 2017 as "peer mentors," under the leadership of psychology teams and funded through time-limited money.
- Following sustained internal advocacy, these roles have been renamed as "peer support workers," re-banded to reflect seniority, and supported by the introduction of a Band 7 peer lead.
- Strong professional partnerships, particularly with clinical psychology, has helped embed and elevate peer roles over time.

C. NHS Band 7 Peer Lead Roles Across Health Boards

- In 2024, each of Wales's seven health boards received one-year funding for a Band 7 Peer Lead to develop a regional recovery college business case.
- These roles are a key test of strategic leadership, tasked with creating sustainable, localised models while aligning with national priorities.
- The initiative represents both an opportunity for scale and a stress test of the fragility of temporary peer leadership posts.

D. Welsh-Language Recovery College in Development (Betsi Cadwaladr UHB)

- Recognising the centrality of Welsh as an emotional first language, Betsi Cadwaladr UHB has committed to developing a bilingual recovery college.

- This will be the first such offering in Wales and serves as an important example of how peer support must adapt to local linguistic and cultural contexts to be effective and inclusive.
- Recruitment has prioritised fluent Welsh speakers with lived experience.

E. SWADS – South Wales Anxiety and Depression Support

- SWADS is an award-winning peer support group run by and for people with lived experience of mental health challenges.
- Since 2013, it has welcomed hundreds of individuals from across South Wales, offering a local, independent, peer-led community that significantly impacts participants' lives.

Conclusion

Themes and reflections from across countries on the state of peer support

This comparative project set out to understand how peer support can grow and thrive in diverse mental health systems. Through interviews with peer leaders, system allies, clinicians, policymakers, and lived experience advocates, a shared set of opportunities, challenges, and structural patterns has emerged across seven countries: Canada, Denmark, England, Ireland, Aotearoa New Zealand, Victoria (Australia), and Wales.

While peer support has different histories in each country; emerging from grassroots activism, NGO innovation, recovery colleges, or intentional government investment, a number of key themes remain consistent. These themes reflect not only what is working, but also what must be attended to if peer support is to maintain its integrity, cultural depth, and system-shifting potential.

The country profiles in this report reveal a powerful trend: peer support is increasingly recognised as an essential part of modern mental health systems. Across diverse countries and healthcare systems, the peer workforce has expanded significantly in recent years, driven by a combination of grassroots advocacy, political action, and organisational experimentation.

Yet this transformation remains incomplete. A shared set of tensions, challenges, and enablers emerged across the seven countries profiled. The following key themes summarise what was found:

Peer support is gaining cultural legitimacy, but remains structurally precarious
Across all countries, peer support is more visible and accepted than ever. However, many roles remain fragile, underfunded, or outside of core service structures. Despite widespread recognition of the value of lived experience, peer work is often still framed as an "add-on" or discretionary innovation which is vulnerable to funding cuts, workforce pressures, or leadership changes. In Ireland, roles created through innovation funding have stalled in scale due to austerity and lack of political follow-through. In England, roles in some NHS Trusts remain dependent on project-based funding or inconsistent local sponsorship.

Strategic policy anchoring changes the trajectory
Where peer support is formally included in workforce strategies, legislation, or system reforms, implementation gains both legitimacy and sustainability. Clear policy commitments allow peer roles to move from experimental to expected. For example, Victoria's Royal Commission and Wales's Strategic Workforce Plan gave peer support formal status, enabling long-term planning, investment, and infrastructure development.

Peer leadership, not just frontline staffing, is critical
The presence of senior peer leaders in governance, clinical systems, education and NGO's is a defining feature of successful implementation. These leaders shape policy, mentor staff, broker trust across sectors, and protect peer values during scaling. Yet many systems lack dedicated leadership roles, resulting in inconsistent direction and succession risks. For example, in Victoria, peer leaders hold governance roles in hospitals and ministries. In Aotearoa New Zealand, Kaupapa Māori leadership has enabled culturally resonant peer models. In Wales, peer-led taskforces have informed national strategy.

Supervision and peer-led infrastructure are core to sustainability
Peer workers cannot thrive in systems that replicate clinical hierarchies or lack peer-informed supervision. Many countries lack embedded supervision frameworks or clear career pathways, leading to inconsistent practice, poor retention, and leadership burnout. Victoria's supervision and mentoring ecosystem is a rare example of an end-to-end infrastructure that spans entry-level to senior leadership. Wales is actively developing national supervision guidance to support regional growth.

Visible, tangible models help shift hearts, minds, and policy
High-profile, well-regarded examples of peer support, especially those embedded in statutory services, have acted as catalysts for broader system reform. These models show peer support as credible, safe, and transformative, reducing scepticism and building political support. For example, Cardiff Recovery College in Wales and the Alfred Hospital in Victoria (with over 70 lived experience roles) have been critical in translating values into action, funding, and policy momentum.

Peer support is a cultural lever, not just a service innovation
Peer support changes systems not only through what it does, but how it does it. When implemented with fidelity, it can shift organisational norms toward mutuality, choice, rights, and personhood. However, this potential is lost when peer roles are tightly controlled by clinical teams or over-professionalised. In Aotearoa New Zealand, peer support is explicitly framed within Indigenous models of collective care. In England, several recovery colleges have used co-production to introduce trauma-informed practice and relational care into risk-averse systems.

Workforce development must be matched by values-based guardrails
Training, supervision, and infrastructure are essential to sustain peer work but must be balanced with peer values. Over-professionalisation, while addressing credibility, can risk stripping peer roles of their identity, autonomy, and challenge to dominant paradigms. Imroc in England and Victoria's Consumer Perspective Supervision offer peer-specific infrastructure that protects role integrity while supporting scale. However, systems without these supports report role drift and burnout.

The grassroots-to-system tension is unresolved but productive
Peer support continues to walk a line between institutionalisation and resistance. Some dilution of values occurs with system integration; however, staying outside the system risks marginalisation. Most leaders see the challenge not as choosing one or the other but holding both: protecting the roots while shaping the future. In Canada and England, NGO and clinical peer support operate in parallel, often with different cultures. In Victoria, senior leaders explicitly work across government, services, and community to maintain this dual role.

Lasting change requires durable governance, not just champions
Individual peer leaders, allies, and champions have driven remarkable progress. But long-term change depends on embedding peer support into governance, contracts, budgets, and quality metrics. Without these structural commitments, gains remain reversible. In Aotearoa New Zealand, peer roles are embedded within Te Whatu Ora [Health New Zealand] at the national level, but regional variation remains. In Canada, progress has been set back in regions where strategic frameworks or funding commitments lapsed.

Health system allies can accelerate or hinder progress
Allied health professionals (particularly occupational therapists, psychologists, and public health leaders) were frequently cited as important early allies in countries like Denmark, England, Wales,

and Victoria. Their support helped integrate peer workers and secure organisational buy-in. However, several interviewees cautioned that this support sometimes reinforced hierarchical or professional-led models, where peer leadership remained subordinate. True partnership requires power-sharing and letting peers lead not only roles but service design and system direction.

Autonomy enables innovation but fragmentation limits equity

Smaller or more devolved systems (e.g. Wales, Denmark, provinces in Canada) offered fertile ground for local innovation. However, they also suffered from inconsistency, duplication, and gaps in quality. In Canada and Denmark, the lack of a cohesive national strategy left peer support dependent on local champions or organisational interest. In contrast, Victoria and Aotearoa New Zealand benefited from national frameworks that enabled local ownership within shared guardrails. Finding the balance between flexibility and coherence is key.

"I do peer support not just because I like the practice, I really do believe it's the most likely way we'll achieve change in the mental health system."

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